midwifery MATTERS

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ISSUE Nº 57 SUMMER 1993

Overseas issue

Home thoughts from abroad
Endangered midwifery practice
Birth behaviour of women
Midwifery in Nepal

ASSOCIATION OF RADICAL MIDWIVES

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OBJECTIVES

1. To re-establish the confidence of the midwife in her own skills.
2. To share ideals, skills and information.
3. To encourage midwives in their support of women's active participation in birth.
4. To re-affirm the need for midwives to provide continuity of carers.
5. To explore alternative patterns of care.
6. To encourage evaluation of development of our field.

The Association was formed in 1976 by a small group of student midwives from different training schools, who were alarmed by the apparent trend towards maternity nurse status in their training.

With growing support from other student midwives, qualified midwives and from women themselves that undesirable trend is at least being challenged.

ARM can feel justifiably proud to have been part of the movement towards a more caring attitude in midwifery, and to have been instrumental in helping alert our colleagues to the threatened loss of our professional independence.

The word 'Radical' is used in its literary meaning of relating to roots and origins, and best expresses the hopes of that early group, that midwifery could find its way back to a position where midwives' skills were used to the full while still taking full advantage of the benefits of modern technological advances, where these are seen to be in the best interests of the woman and her child.

In other words, the hope that the true meaning of midwife ("with woman") will once more be realised in practice.

The Association is self-supporting, financed by membership subscription and sale of literature and other items. It is run by its members, who give of their time and effort voluntarily by co-ordinating and editing *Midwifery Matters* and by joining the Steering Group and working parties. The only paid worker is the secretary, who receives the equivalent of an E grade post salary for approximately 25 hours per week.

NATIONAL MEETINGS

We meet regularly to exchange views, hear of developments in maternity care and share our skills with each other. Members are encouraged to bring along non-member colleagues and friends. Meetings, which are open to all who are concerned about maternity care, are held every three months, on the third Saturday of March, June and September, and the second Saturday in December. (One of these meetings will be the AGM). Venues vary around the UK to give everyone a chance to attend during the year, and will be announced in *Midwifery Matters*, together with directions and map.

The registration fee is £10 for non-members and £8 for members, to include lunch and light refreshments during the day. Paid-up ARM members can claim a refund of travel expenses over £10 based on the most economical transport, funded mainly by the registration fee. Overnight accommodation is always available, usually in local members' homes, (bring sleeping bags if possible).

OUR QUARTERLY MAGAZINE

Midwifery Matters is our line of communication between members, and also from ARM to others concerned with maternity care. In principle it will be published quarterly and will include reports from meetings during the last three months.

Although the actual publishing and editing is lodged with the South Wales Group, the Regional Groups take turns in providing the main features, which may sometimes illustrate a common theme. The rota for this input is made up at the Annual General Meeting from volunteer Regional Groups.

Regular inclusions such as letters, book and film reviews, forthcoming events and other items of interest are always needed. Artwork is always welcome, as are good photographs. We can return originals.

This is YOUR magazine, let us hear from YOU!

IMPORTANT

Read the label on your *Midwifery Matters* mailing envelope before you throw it away, and check your subscription renewal date. Unless you have an active standing order, the date shown indicates the end of your subscription. This may be your last magazine unless you renew before the next issue comes out.

MEMBERSHIP

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(See Subscription Form inside this magazine)

Please do not send foreign currency, since bank charges and exchange rates reduce the final payment, and make this method unacceptable. £ Sterling only please!

1993 NATIONAL MEETING VENUES

The following members volunteered their region for the National Meetings in 1993:

20th March – Birmingham – Sarah Montagu
19th June – Hexham (Northumberland) – Shona Kerr
18th September – Manchester AGM – Sue Cripps
11th December – Bristol – Jane Tucker

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The views expressed in this magazine are those of individual contributors and are not necessarily those of ARM as a whole.

Information on the events page will be confined to basic details only. Any further elaboration will be charged the usual rate.

Advertising is accepted at the discretion of ARM. We are unable to accept inserts, all other enquiries should be directed to the Magazine Group.

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ISSUE No 57
JULY 1993

Editorial

At the last AGM when setting the rota for 1993 issues of *Midwifery Matters*, we thought it was time to include our members living overseas. We have often published articles, features, letters, etc., from other countries, but this time we decided to write to each member individually asking for input to the June 1993 issue, and as you see, the response has been very good.

We have around 50 members living outside the UK. Some are long-standing members of ARM, having joined while training or working in the UK, and have subsequently moved abroad. Sometimes these moves were to accompany a partner taking up an overseas contract, which entailed moving the whole family away from the UK. Not all of these members have been able to work as midwives in their new surroundings, due to registration and validation problems, and report frustrating negotiations with the national and local bureaucracy. This may sound strange to us, but apparently our long-held belief that British midwifery training is held in high esteem overseas, no longer holds true. It seems that the procession of potential midwives seeking the highly prized British qualification in midwifery is dwindling. Could this be as a result of our move towards the use of technical aids and reliance on obstetric policies and protocols?

Wood carving from Southern India, TANTRA ART, 18th Century. AJIJ MOOKERJEE COLLECTION. Gulbekian museum, Durham, England.

Some of our members have gone overseas to work as midwives, either as volunteers in deprived areas, or through the agencies recruiting midwives for other countries. Others are abroad with the British Forces Overseas, based in Europe and elsewhere. Several of our overseas members have never been to the UK, and practise either independently or in hospitals in their own countries. The various routes by which they came to join ARM are fascinating, some have talked to other midwives at conferences and study days in their own countries, others have seen our articles reprinted in their own professional journals.

Continued contact with ARM is valued by our overseas members, in order to keep up with current issues and feel 'involved' if only from a distance. I'm sure this issue of *Midwifery Matters* will give a good flavour of the conditions in which they work, and the ways in which their practice differs from midwifery in the UK.

We might consider making the 'overseas' issue a regular event, perhaps every two years? We look forward to your response.

Ishbel Kargar (Secretary)

The editors would like to apologise for articles not appearing in this issue. We had a very good response from midwives, particularly in Canada, and to enable us to present a balance of contributors we have kept these articles for publication in the near future.

We would like to draw your attention to the change in date of deadline for publication in *Midwifery Matters*. This will now be the 10th January, April, July and October not the 15th.

This change is to enable Polly and myself to maximise the time spent before sending copy to Argraff.

Members should also note that copy should always be sent direct to 71 Plymouth Road to avoid disappointment and delay.

Sandra Arthur
Editor

Home thoughts from abroad

FEATURES
GERMANY

I am a Scottish trained midwife, although English by birth. My midwifery experiences of hospital birth, community midwifery, home births and domino deliveries and independent midwifery are all gained from Scotland.

I have the experience of living and being married to an obstetrician and so gain a lot of information from him. What, you may then ask, can I possibly comment on with so little experience of midwifery in Germany? The question I asked of myself was: what right did I have to make judgements based on very superficial gleanings.

It was on this point that I saw parallels with Scotland. My impressions here so far, have been very mixed. It appears that in the system, midwives have very little autonomy. They must have a doctor present at every birth; there is no community service as we know it, and in this area rarely is there a request for home birth. Labour wards are severely understaffed and the CTG provides the only constant companion for anxious couples. Midwives do not work in postnatal and practises with breastfeeding are outdated, neglectful and ultimately unhelpful for women wishing to breastfeed.

If women require antenatal care in hospital they are admitted to the gynaecological wards where there is no midwifery support. In the community women are cared for by 'their gynaecologist' (usually male) and so once more not much room for midwives.

I have discussed these issues with various practising midwives here, and all are agreed that the situation must change. However, one of the major ingredients for change appears to be missing; and that is the will of the women themselves to change their experiences of pregnancy and childbirth.

It seems that the German medical system has done an excellent job of convincing women of the pathology of their pregnancies. They appear to readily accept the need for numerous vaginal examinations and ultrasound scans and blood tests antenatally. (Do not forget the doctor is reimbursed from the client's insurance company for every test he performs.) Regular CTG's from thirty-eight weeks on inevitably cause anxiety and numerous unnecessary hospital admissions, and as we all know, once in hospital there is always the temptation 'to get things going' with the inevitable resulting cascade.

Germany may be lagging behind in its efforts to publicise the good things that are happening there, and so I want to continue with applauding what is happening here.

I was inspired by Susanne Robert's practice in Cuxhaven. She runs regular antenatal birth preparation classes; she works part-time in the local labour ward and she works independently providing much needed and valued postnatal care. Inevitably women are now beginning to request her presence at their births; the logical next step. However the demands are great and without a partner to share the work results in a frustrating limit to what she can do.

I have met several other midwives who also combine their hospital work with community postnatal care. Midwives throughout the country are taking on the care not provided by statute in their efforts to provide a better service for women.

I have been in correspondence with Eva Maria Miller-Markfort – who practises independently and is very busy with home births. She put me in touch with the German Independent Midwife's organisation. Through Susanne and midwives I have met in this area, I have become aware of midwife-led birth centres in some of the larger areas such as Berlin and Hamburg, where women are being offered a very different service to the one I have so far experienced.

So there is a network here, a network for change, and the sooner I can get to grips with their language, (*it is very hard!*) the sooner I can become a part of that network.

The CTG provides the only constant companion for anxious couples

Just to finish, a birth story. Last Sunday I was meeting my husband from work. A birth in the breech position was impending and he asked me if I would like to attend. I immediately said no, because I had no wish to intrude as I felt it would be unfair to the woman, her partner and the midwife. So I patiently sat in the staff room pretending to be conjugating German verbs and wishing I was a fly on the wall, when my husband appeared, grabbed my arm and assured me I was welcome.

I witnessed the lovely birth of a girl who was born with her legs modestly crossed. Her parents were so welcoming and so was the midwife. I was very grateful and delighted to be a part of such a special event.

Despite being 'one of them', my husband is a wonderful doctor and at times midwife. He conveyed a feeling of quiet and calm. Many of the births he is called to because the midwives have given up, result in normal vaginal deliveries. He believes in women and he listens too, and he is German hence my arrival here. Enough said. I cannot wait to call myself a midwife again; but for now it is back to the Hausaufgaben (homework).

Tschuss!

Helen Shallow, RM, ADM

GERMANY

Endangered midwifery practice?

The union of the two German states has definitely had an influence on the situation of midwifery and childbirth in the ex-GDR. And overall we observe welcome and long overdue efforts to liven up midwifery and to strengthen the status of the midwife and self-confidence of the childbearing woman.

I decided to report on a conference I organised in December 1992:

- to tell you a little of the work of Liselotte Kuntner from Switzerland,
- and to show how an event can be organised without the back-up of baby-milk firms and/or local hospital administration.

A little bit about myself to start with:

I trained in the UK as a nurse and midwife and became a member of ARM right at the beginning of my training. I have two daughters, both were born at home, one in Germany, the other one in Yemen. I lived overseas for many years (Yemen and Pakistan) and returned to Germany in 1989. Once here, I became very frustrated when I realised what midwifery and hospital delivery were really like here! I decided to make the best of the situation, and started working as a self-employed midwife. Two years later I was offered a part-time job at the local labour ward. At the moment I am combining hospital work with private work (antenatal classes, postnatals), and find myself very much overworked!

Optimistic that change is possible I decided to concentrate my efforts on the status of the midwife, continuity of care and the reclaiming of active, upright birth. I realised that improvement is very slow to achieve in a place like Cuxhaven, where there is no other hospital as competition. I felt that a strong impetus had to come from outside 'to shake people's minds up'. I invited Liselotte Kuntner from Switzerland to Cuxhaven, having heard that she was coming up north anyway to hold lectures at Bremen University.

Liselotte Kuntner is a renowned expert on upright and active birth. She is a physiotherapist, and had her own practice for 20 years. She has three children, and one grandchild. In 1978 she started research into the subject of childbirth behaviour and birth positions. She studied ethnomedicine at Zurich University and did field studies in Sri Lanka, China, Nicaragua and Cameroon. From 1983 onwards she has been lecturing at Zurich University on childbirth practices and motherhood in the context of ethnology. She has been guest lecturer at numerous Midwifery and Medical Schools and Universities in Switzerland, Austria and Germany. In 1985 she published her first book 'Die Gebarhaltung der Frau', unfortunately not yet translated into English! In 1987 she designed the MAIA birthing stool, which is becoming more and more popular in many labour wards on the Continent. Her second book on the experiences with the MAIA stool followed in 1991.

Ms. Kuntner is a convinced feminist, this seems to be the driving force in her fight for the improvement of childbirth and the autonomy of the childbearing woman. My impression of her is of a 'gentle fighter'. She makes no compromise in her mission for the improvement of women's experience of childbirth. She has, however, a very sensitive skill of presenting her cause in a fashion which is non-threatening and non-confrontative, and therefore so much more efficient. She succeeds in convincing people, who come to her presentation with the intention of 'not becoming convinced'!

Like most other highly professional and successful women she puts great stress on the importance of very sound and detailed knowledge of her subject, the ability to converse in scientific terminology, where appropriate, and good skills in communication and rhetoric.

Wherever she has held workshops or lectures some change has been initiated, major in some places, more modest in others. She feels very concerned about the observations she made during her field studies overseas. Traditional birth practices and positions are – as we all know – 'endangered'. Wherever Western influence comes in, we observe an import of the worst (i.e. Nestlé, lithotomy position), and often (exemplary projects excluded!) a lack of concentration on the factors, which have made childbirth safer in developed countries. Those were exactly my impressions in Pakistan and Yemen!

Organisation of the 'event':

I decided to do the initial planning and organisation totally on my own. Most of all, I felt it was wisest not to inform the obstetric department of things to come, to ward off negative vibrations!

Step one was to find sponsors for Ms. Kuntner's fee. It was a fairly large amount I had to raise, but I was lucky inasmuch as Bremen University was paying the travelling expenses from Switzerland.

I managed to convince the following firms of the good cause:

- my bank (private and business account, house mortgage),
- my car dealer (business car, his wife an ex-client),
- Benetton (they do baby clothes in Cuxhaven),
- my bookshop (I am a very good customer there),
- a dental lab (babies might need braces one day!)
- one of the local health insurance companies,
- a medical supply shop (elastic stockings for pregnancy),
- my plumber (no obvious connection, except friendship!).

The attraction for them was, of course, the possibility of tax deduction and the offer of publicity via discreet mention on posters and invitations.

Step two was the question of the venue. I spent a long time looking at various possibilities, like adult education centre, school halls, etc.. In the end I chose a church hall. The advantages were the size of the place (my friends suggested I might suffer from loss of reality in my expectation of a large audience, but I was right in the end!), and access to a tea kitchen. The rent for two evenings was a very modest donation to the church.

Step three was the advertising. A friend, computer expert and also husband of an ex-client, designed the poster, hand-out sheets and a very stylish invitation card. I decided to photocopy everything as the quality was as good as printing, but the work cheaper.

Six weeks before the event I sent out invitations to obstetricians, midwives, health workers, hospitals, covering also three other towns in the area. Thankfully, I had voluntary helpers, who distributed posters and hand-out sheets all over the place. Two weeks prior to the occasion I informed the press. An ex-client is a journalist at the local paper and she accepted my suggestions as to how the article might be worded.

Final tasks were:

- book stall, my bookshop took this on,
- video equipment, on free loan from a local firm,
- two slide projectors and screens, on free loan from the local council,
- refreshments for the workshop, organised by my friend's cleaner.

As the donations of the sponsors were totally spent on Ms. Kuntner's fee, I needed other sources for the remaining expenses, like photocopying, considerable telephone and postage bills, church hall rent, refreshments, tea lady's pay, etc.. From the German Midwives Association I claimed an allowance which is granted for refresher courses on a local level.

The announcement of the event caused considerable tension, even hostility towards me, in some places (i.e. the labour ward), some midwife colleagues included. Although I was comforted by the positive reaction and excitement of women and my daughters, who gently suggested that we occasionally direct the topic of conversation away from "upright birth"!

Ms. Kuntner's first talk was held in front of a mixed (experts and lay people) audience. Her visual aid was the double slide show, a very clever way of presenting historical developments, and highly effective, for instance, by unmasking modern obstetrics next to a slide showing the simplicity and beauty of birth 'left alone'. The discussion that followed the presentation was more than animated, and many of the present 'experts' heard comments from traumatized women, they would rather not have heard.

Traditional birth practices and positions are – as we all know – 'endangered'.

The workshop for obstetricians, midwives, antenatal teachers and physiotherapists took place on the following afternoon. Ms. Kuntner's presentation was held in a very scientific manner and was highly convincing. The consultant and both senior registrars were present amongst other obstetricians. A video of a delivery on the MAIA stool was a practical and inspiring demonstration for those birth attendants who feel very insecure about alternative positions. Finally, everybody had a chance to try out the MAIA stool, and experiment with the various possibilities it offers. To my greatest surprise the consultant decided to buy the stool, including the floor mat that goes with it, for the labour ward. The first 'stool delivery' took place during the night following the workshop, and we had quite a few since. A combination of pressure from women who had attended the lecture, or were told about it, and a growing acceptance amongst the midwives has led to this development.

However, this is a very small beginning, and some resistance and opposition is still in the air! The necessary learning process has to be that the question is not just 'bed or stool'. A comprehensive change of attitude touching on many other areas of midwifery and obstetrics (power, hierarchy, communication, sensitivity, privacy, integrity, etc.) will be essential in achieving a care that 'allows' for more than free movement and spontaneous choice of position.

Ms. Kuntner is hoping to present her work in Britain in the near future, either in the form of lectures and workshops (which would have to be translated simultaneously), and/or through translation of her books and brochure. Interested organisations should make contact either with me or directly with her:

Frau Liselotte Kuntner
Kornweg 6, CH-5024 Kuttigen, Switzerland
Tel. 0041 – 64 – 372389.

I am thankful to have met a magnificent woman like her. I have drawn new courage and learnt a lot. From the organisation of the event and the successful outcome I have gained new confidence.

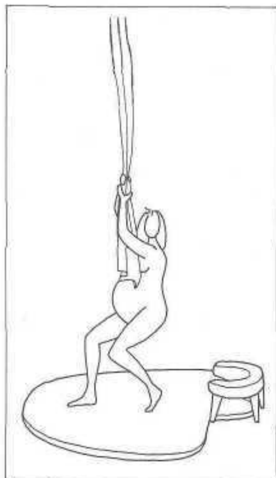
With permission of Ms. Kuntner I include the content of her brochure confident that copyrights will be strictly respected!

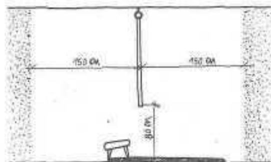
Susanne Roberts
Midwife, Cuxhaven, Germany

GERMANY

Birth behaviour of women

In most birth systems of a traditional kind the active birth behaviour of women is very important as it can reduce pain and ease birth. By 'active birth behaviour' we mean moving and walking *around, using certain body positions* to help and ease birth as well as relaxation and breathing between contractions, according to the needs of the woman giving birth. Physiological behaviour, which means behaviour adapted to contractions, includes choice of an upright delivery position.





Most cultures prefer an upright position at birth

Most cultures prefer an upright position at birth, i.e. squatting, kneeling, standing or sitting, supported by an assistant or the husband, on a stool or a birthing chair or in the knee-elbow position.

In Western birth systems knowledge of the active role of women during childbirth and of an optimal birth behaviour has been all but lost. There are, however, many other societies which still retain this knowledge and which have influenced today's obstetrics. All over the world, women walk, sit, stand or squat during birth. They move their bodies freely to find the most comfortable and helpful positions to use and sustain contractions and to give birth. All this makes birth easier and safer for both mother and child.

Several new scientific investigations show the advantages of such reasonable birth practices. Nevertheless many women are denied these options and are forced to give birth in a passive dorsal position (lithotomy position). This can disturb the physiology and psychology of the birth process and can cause undesirable complications.

We quote point 17 of the 'General Recommendations' of WHO (see the literature): "Pregnant women should not be put in the lithotomy position during labour or delivery. They should be encouraged to walk about during labour and each woman must freely decide which position to adopt during delivery."

With respect to the well known advantages of free mobility and the upright body position of women during birth we conclude that an active behaviour and an upright delivery position support physiological and dynamic processes at birth and are beneficial for the physical and psychological condition of mother and child.

All professionals taking care of pregnancy and childbirth as well as pregnant women themselves should strive to change undesirable obstetric practices and support the introduction of a physiological birth behaviour and the upright body position.

Supplying 'lost' knowledge of birth behaviour will help women to use their own abilities, instincts and resources at birth and to assume the autonomous role to which they are entitled. Women must be enabled to acquire again the 'Art of Birth'.

Advantages of freedom of movement during birth and upright birth positions:

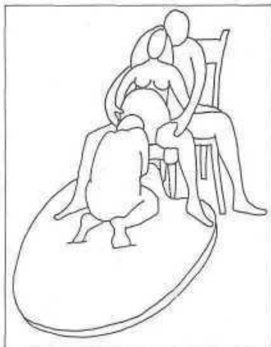
- Birth channel widens.
- Movability of the pelvis is almost optimal, best while in a hanging position.

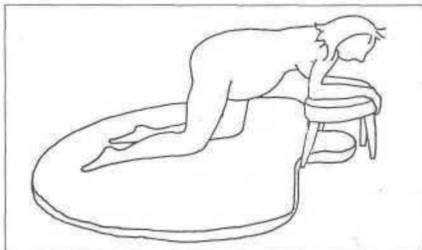
The Maia stool

- In a standing or squatting position, because of position of pelvis and lumbar vertebral column, the birth channel is straight and almost vertical. This makes it easier for the child's head to move downwards.
- Expulsory muscle power and gravity can only act together in an upright position to support dynamics of birth.
- Contractions of the uterus are stronger and more regular.
- By moving, walking around and changing positions, contractions are easier to use and sustain.
- It is easier to relax between contractions.
- Behaviour of the women adapted to contractions relieves pain.
- Easier opening of cervix.
- Shorter dilatation period and shorter duration of the whole birth process.
- Contraction of abdominal muscles are more effective.
- Pelvic floor muscles stretch and relax better.
- Less risk of perineal tear and of the need for episiotomy.
- Women are more active and have better control over their bodies.
- Mother's breathing improves considerably.
- Prevention of the utero-vascular (maternal hypotension) syndrome, especially in a forward-leaning, supported position.
- Compressive effects of the uterus on veins and arteries are lessened.
- Reduction in maternal cardiovascular disturbance.
- Cardiovascular status of mother and child (fetus) improved.
- Blood supply for placenta improved.
- Fetal heart frequency improved.
- Prevention of fetal distress connected with maternal hypotension syndrome. Relief of aorta cava compression and of pressure on the umbilical cord.
- Better Apgar scores following delivery.
- Hormone metabolism is improved (prostacyclines and endorphines). On the average the level of prostacycline increases when a woman changes her position from lying on her side to standing.
- Body contact with helpers has a relaxing effect on the woman. The regulation mechanisms of the limbic system may trigger the production of endorphines.
- Reduction of stress, anxiety and tension decreases adrenaline production. Moreover, the effects of the hormone oxytocine are supported. (Use of warmth has the same effects.)
- Need for drugs (contractive or relaxing medicalisation and pain-killers) is lessened.
- Emotional mother-child-bonding will be initiated and supported by the immediate visual contact in an upright position.

© 1991
Liselotte Kuntner
Physiotherapist
Switzerland

The lithotomy position can disturb the physiology & psychology of birth





GERMANY

The liberal midwife

A threat to today's hypermedicalised obstetrics?

I'll start by saying "Yes, of course, she is", and I'll try to show how and why.

There's a feeling in the air – things are happening: midwives' meetings, midwives' further training programmes (all in our own time and at our own costs), midwives' gatherings, midwives getting angry, midwives leaving the hospitals and starting to practice on a liberal level: midwives looking with envy over the fence to their colleagues in the Netherlands, who seem to be so far ahead. And, last but not least, midwives getting together and opening up birth centres, to meet the ever increasing demand from women who don't want to go and have their babies in a hospital.

Now we are very lucky because our social security system is such that we can settle the costs for our services directly with the particular health insurance company of the future mother.

To show how this is done I'll tell you about my own position. After many years out of work for family reasons, I started back in 1988 to work in the labour ward of a small country hospital (about 500 births a year – that's the way we evaluate the size of an obstetric ward). It took me some time to get back the 'finger-tip feeling' – and learn to handle this awful machine that you attach women to during labour.

That was not what I remembered about women having babies in my early midwifery years.

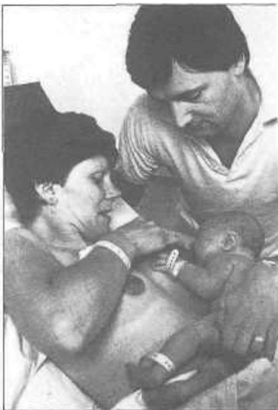
About three years ago I took over the antenatal classes, and I suddenly saw an opportunity to throw in my weight on the other side of the scale. From these classes I choose the women with all sorts of complaints, be they purely somatic or of psychic origin, and I propose to visit them at home, to give them a chance to have someone to talk to – so many are so terribly alone with their fears and frustrations. These are only too often a direct result of all the check-ups and controls during pregnancy – 'just in case'. So it doesn't reassure the women at all to have yet another scan, another blood test – they fear that something must be wrong, otherwise the doctor wouldn't do all that.

I've got very good results with reflexology. I've taken a second course in hypnosis and shall start using it as a deep relaxation for hypertension, pre-term contractions and so on. For the health insurance this figures under "assistance for pregnancy complaints" and is being paid about £5 per half hour. I'd love to learn more about homeopathy, but it seems to be rather difficult.

Doctors don't often like midwives meddling in the care for pregnant women, many are hostile. They realise once a woman goes to a midwife, they lose control over women. With the midwife women learn self-determination. They even start refusing yet another scan, another odd examination, the amnioscopy at the end of pregnancy. Often they don't show up for their postnatal check-up when they are being cared fo by a midwife, they stop breastfeeding with herba teas and things like that instead of those wonderful little tablets prescribed by the doctor (which make them feel sick often and apparently are rather dangerous). And later do not come back for 'the pill' because they have been fitted with cervical caps.

Women choose to have their babies at home, with the assistance of a midwife, no doctor, no monitoring, no operation theatre at hand.

It is wonderful helping, encouraging those women who do want something different. It's lovely seeing them mature through this unique experience and become proud and self-assured. It's fun watching the young fathers growing overnight virtually into their role of provider and protector for his loved ones.



Fortunately in our country we have a law which says that midwives are allowed to look after a woman in labour and help her to give birth without the assistance of a doctor – whereas a doctor has to call upon a midwife under the same circumstances. So every couple is free to choose whichever setting they wish for

the birth of their baby – if only we had more midwives doing liberal work. The problem is – you guessed it – a financial one. It just doesn't pay well enough. We get about £80 for a home birth – for up to 12 hours, a routine pregnancy check-up is £3, a postnatal visit (no time limit) is £12. This is before deductions of any kind. Just now, the professional risk insurance has gone up tremendously. So many colleagues do as I do – they stay part-time in the hospital, to have one secure income.

Still, I've decided to take the big jump. We'll soon start building a little surgery at the back of the house, and as soon as there is more work on the liberal side, I'll stop working in the hospital. I've stopped fighting for improvements within the system – it takes so much energy, and there is so little hope for change. I'll soon be 54 years old – my son is in Wales and my daughter takes her 'A' levels soon. I've married a second time, and my husband is really the driving force behind me. He helps and encourages me, and as he is a psychotherapist and – soon – 'health practitioner' (Heilpraktiker), something specifically German, I do learn a lot from him. So I'm looking forward to the last part of my professional life with excitement and joy – helped, as well, by many good and wise colleagues, on whom I can call day and night when a problem arises. Together, I'm sure, we'll be able to tilt the scales in the other direction. It's high time that we did.

Eva-Maria Miller-Markfort
Midwife
Germany
March 1993

A midwife accuses

Article from 'Rheinischer herkun und Wels' – Jan. 1993.

"People who give us courage" – meaning, people who encourage us to do the same, to fight for something, to stand up for an idea, etc..

"I'm not a courageous person, I'm a coward like anyone else, but there are situations where I won't move an inch, there I'm in keeping with Martin Luther and his stubbornness." Christine Hersmaun lives in Erfurt (just like the then not yet very rigid Luther) and dared again and again the rebellion of her conscience against the doctors of the local 'Frauenklinik' (Hospital for Gynaecology and Obstetrics).

This happened again in 1992: but the drama, in her own words "a hopeless battle", has its preceding story:

Christine Hersmaun, as a student midwife, witnessed for the first time in 1964 what happened in Erfurt, one of the 'show-off' hospitals of the then German Democratic Republic: doctors never tried to resuscitate premature babies of about 28 weeks and around 1000g birth-weight – on the contrary, midwives were advised to keep ready buckets and bed pans filled with water to 'dispose of' the still living babies in there, meaning, to let them die, even to drown them. From that moment on they were declared 'stillborn' and didn't burden any statistics. (For the GDR it was important to have good records in international comparisons of neonatal mortality rates.) They (the dead babies) did not incur any further costs, neither for the individual medical treatment, nor in follow-up costs like birth-prime, supplementary maternity leave or an old age pension bonus for the mother.

Because Christine Hersmaun didn't want to participate in these deliberate killings, she changed to another hospital straight after she finished her training in 1965. When she came back to Erfurt in 1982 and realised, that the old practice was still in use, she wrote a short but very clear letter of protest to the Chief Registrar. This alone was a foolhardy action in the old GDR-times. She herself calls it today – without trying to boast – "kamikaze".

1987 she went to a judge to air her reproaches but the accusations weren't taken up then, even less did it come to the tribunals.

Only last year, in 1992, there were two court cases (reminder: the 'wall' fell in 1990). First, things didn't look too good, but finally she got through with her accusations against two of the doctors. Needless to say, that they didn't lose their approbation.

Still, she is not allowed to work as a midwife any longer. Her court case at the industrial court is still pending. She finds the odd night shift here and there, she works as a charwoman occasionally as she's got to look after her 90 year old mother and her three children. And she's fighting for a law that defines the criteria of 'life' after today's knowledge.

She had always hoped to be able to reduce her workload at the age of 50, Christine Hersmaun says. She feels exhausted. But she knows that there is strength that lies beyond all physical and psychic power.

For this strength she is asking so as not to stop where she's standing now.

The attitude of Christine Hersmaun is ill-defined with courageous. The fact that she's alone today just like in those days, the fact that she's got to fight this battle at all is a misery for our country and its medical service.

Translated by
Eva-Maria Miller-Markfort

GERMANY

Home birth – a diary

Bettina Tuistig, former chairwoman of the Association of Liberal Midwives in Germany (BfHD) writes:

A colleague and friend was expecting her second baby. A home birth was planned. A few days before due she started having contractions. I mentioned this to my daughter Levi who always participates a lot in my births. She said "Oh, wonderful, I'll come with you". My colleague said "Fine, bring her along".

I had always promised Levi that I'd take her to a home birth once she was over 14 years old, and this seemed to be a good opportunity. Levi was absolutely filled with this experience. She no longer wanted to go to school, she only wanted to become a midwife and have children herself.

Diary of Levi Tuistig

***Thursday, 24th October 1991,** 10.30pm – Today I witnessed my first birth. Hille and Thomas didn't mind my being there. We arrived at about 7.30am and had breakfast with Thomas. Hille's contractions were already quite strong. She went to bed, then. Somehow I had been afraid beforehand, that I might just be a spectator. But then mummy went to visit another woman, and I turned on the central heating everywhere. It may sound funny, but it was just the right thing to do. I wanted – I had to be useful for something, be responsible for something, even as little as that.*

Hille went into the bathtub again. She's always feared not to be able to get out of it anymore, to die, but she had to decide by herself what was good for her. But in spite of this she groaned "Help me", or "Thomas, help", "Levi...."

After a while mamma examined her because of something, and the waters broke.

Then she clasped my hand. It was a feeling quite out of one's mind! She needed me! Thomas was sitting behind her, holding the other hand and the other knee. Now the little head emerged. It came the other way around, that is, it looked upwards in my direction.

The feeling I had then is not to be described (undescribable?) Suddenly, one awakes, or one falls into deep trance. No, my inner eyes were opened through Hille's vagina. And only when the shoulders were visible, it suddenly became real. There, where there had been only a woman before, there were two suddenly. A mother and a baby!

Even if you know beforehand, a child is coming out of there.... but when it really comes, then! When you live the experience at first hand! And Hille, too, how she labours and suffers and squeezes my hand, it's out of this world.

And suddenly it appears. Somehow you can't prepare yourself for this. An experience like that – you can't imagine how it's really going to be, and therefore you can't prepare yourself for it.

She was born at 1.21pm, and I was there! I've been holding Hille's hand, and I believe that that was decisive. I helped her (them). 10.23pm.

Levi Tustig, age 15 years, Germany
Translated by Eva-Maria Miller-Markfort

SPAIN

Where have all the midwives gone?

Elizabeth Williams reports from southern Spain on the lack of midwifery care.

On the outskirts of a market town in the hills o southern Spain stands a gleaming white building – the large new hospital – built to serve the needs of the surrounding villages. Here it is that women come to have their babies. Years ag they delivered at home with local women helping summoning the doctor for emergencies. Now doctors hold regular surgeries in the smaller villages, and there are health centres in the bigge ones. In the district hospital itself there are five midwives – each working a 24 hour shift to cove the week. Every year there are 4,000 deliveries.

In the past, antenatal care meant that you saw the doctor if you thought you were pregnant anc then not again until you were almost ready to deliver. Nowadays a woman will see her local doctor to have her pregnancy confirmed, and two or three more times before the birth. At 4 months' and at 8 months' gestation she will have a scan at the hospital. Routine checks are made at each visit and any problems are investigated as they arise. However, at no time during the pregnancy does she meet a midwife. There are no practising midwives in the community. There are no antenatal classes at the new health centres. There are no midwives to run them. While it is rightly assumed that childbearing is a normal and natural process, it is wrongly taken for granted that women do not want more information and support at this important time in their lives. Many Spanish women, faced with minimum provision of care, hedge their bets, and make sure they see a doctor every month by paying to go to a private clinic.... at £50 a consultation.... as well as attending the health centre. Private keep fit classes were recently swamped by pregnant women for whom nothing else was available. The first time they see a midwife is in the hospital when their progress in labour is assessed by a vaginal examination.

This was our first glimpse – a small woman in a green cap and gown, slowly plodding towards us down a long corridor at 3 o'clock in the morning.

It was Su and Jon's first baby and despite their fluency in Spanish, familiarity with Spanish

bureaucracy, and integration into the Spanish culture, the whole process was proving bewildering. The masses of books and leaflets sent out from England by well-meaning friends and relatives were frustratingly inappropriate...., constant references to services taken for granted in the UK and not widely available here. Antenatal classes which I ran specifically for them, consisted of breathing, and relaxation, and attempts to answer their many questions. One major problem was lack of information at a practical level. Hoping to tackle this head-on by demanding to know what was going to happen we found that to get the answers we had to know the right questions to ask. Explanations for procedures were rarely given – medical personnel were obviously not used to answering a lot of questions and we felt we were 'fussy foreigners'. As pain relief is rarely administered I felt it was important to be able to guarantee Su that either Jon or I could remain with her throughout her labour. Two separate doctors assured us this would be no problem, at the same time dissuading us from actually getting the permission of the hospital head, as he might say no. Better a probable yes than to be blocked by a definite no. We also tried to get in to see the room where she would deliver. We did peep into the postnatal rooms which are also used in the first stage of labour, but were refused admission to the actual delivery rooms. Everyone enthused about how wonderful natural childbirth was but Su's anxiety levels about the hospital remained high.

Her pregnancy, however, progressed normally and she went into labour a week after her expected date. On arrival at the hospital a green-gowned midwife examined her and sent her downstairs to relax and rest as she was "not in labour". She slept fitfully, constantly bothered by weak but relentless contractions. Towards morning, Rosario, in labour was admitted to the other bed in the room.

A few hours later Jon and I were turfed out as the doctor did his round and a different midwife carried out another VE. This time she snorted contemptuously that Su was not in labour and that she had better calm down as she was not having any proper pain. She then walked out, and we were allowed back in again. There was no reassurance, no explanation, no advice. They did refuse to allow her home. I also managed to elicit that the cervix was, in fact, soft and thinning, and that once she had dilated to 3cm she would go upstairs. Su was desperate to know what was going on. She felt she was 'doing badly' and needed us to tell her she was coping well. The nurses rarely came in – when they did it was to ask Su what the fuss was about, not to encourage or explain. Rosario now began to scream loudly and uncontrollably. Her mother called a nurse, the nurse called the midwife who rushed her upstairs. Two hours later she returned with her baby. This was very dispiriting for Su as Rosario had been admitted after her, had made an amazing amount of noise, had apparently been seen to immediately, and though whisked away in agony had come back with a baby....

At seven Su's contractions became longer and stronger. We called the nurse and she got the midwife. Su was taken upstairs, on her own, away from us into the delivery room. Half an hour later the midwife came to get Jon. I asked what was happening. "Three centimetres dilated and the waters have been broken." An hour passed and the midwife came out again. "Fully." Only then was I allowed in, but when Su appeared too exhausted to push I was shunted out again. The baby was delivered in theatre by Ventouse Extraction and Jon was allowed to be present. Two days later Su was discharged. She and the baby were checked and an appointment made for them both at the local health centre for the following week. No specific postnatal care was offered. The midwife was not seen again.

Explanations for procedures were rarely given

Penni Bestic

My reactions to Su's labour were very strong. Why had so little attention been paid to the psychological aspects of her care before, during, and after delivery? Why was routine midwifery care apparently non-existent? Because it was not, and had not traditionally been perceived as necessary? Because the skills of the midwife were *underrated and inappropriately used – reducing* her to a machine for conducting VE's? Because of a shortage of midwives? Because more women are not demanding continuity of care as something they and their babies are entitled to?

The midwife was not seen again

Admittedly Su was out of her culture – had she been Spanish she would have had the support of her family nearby and the advice of *neighbours and friends within her community.* Perhaps, too, she posed a threat to the hospital as only the second or third foreigner to have her baby there. Perhaps I too was a threatening outsider.... Basic routine checks were carried out and there was a minimum of intervention, but should this be described as 'natural' childbirth when a supportive, caring professional midwife is *seen as an extra? If shortage of midwives is a* factor, what will happen in the UK when midwives are an expensive luxury?

Elizabeth Williams
midwife Spain – *Feb. 1993*

BELGIUM

Birth in an American army 'field' hospital

I have been an Associate Member of ARM for two years, and wrote about my desire to become a midwife in Issue 48 of *Midwifery Matters* 1991. I am currently living in Belgium, but this year expect to return to the UK and consequently will be able to apply for a preregistration midwifery course. I've spent the last couple of years obtaining the necessary GCSE's, and gaining invaluable 'work experience' as a volunteer for the American Red Cross.

I was expecting things to be different to the antenatal care I'd experienced as a British mother in an NHS hospital, but what surprised me more was how much real 'nursing/midwifery' I was allowed to do as a non-medical volunteer.

On an Ob (obstetric) morning, I screen the clients before they see the obstetrician. Testing urine, weighing them and taking their blood pressure. I then act as a chaperone, and there is always endless paperwork, as well as cleaning and stocking exam rooms.

Gyn (gynaecology) mornings are sometimes even more interesting as I not only screen the patients, I am allowed to assist the doctors in many minor procedures which are performed in the clinic; smear tests, colposcopy, IUD insertions and removals and even endometrial and cervical biopsys.

Episiotomy is common here especially on first deliveries as they do not like mothers to be long in the second stage

I now have additional responsibilities having qualified as a Red Cross instructor teaching the 'Healthy Pregnancy, Healthy Baby' course. Basically it is the same as antenatal classes, although this course seems far more detailed than I remember classes in Britain to be, except that here the emphasis is on medical knowledge rather than the emotional side of things. To qualify as a candidate to instruct I had to answer a hundred question test and obtain over 80%. I was terrified at the time as I was taking the course with some obstetric nurses. I need not have worried as I actually scored 93%.

We have a huge cross-section of expectant mums here: 15 nationalities, including American, British, other Europeans, and even some mums from the Middle East. So the attitudes and traditions with which we have to be aware are very wide-ranging, although in practice few alternatives may be offered, for instance, there are no female obstetricians available.

A large proportion of our mums are American Service on active duty. They work up until the birth and then have six weeks before returning to duty. At three months post-partum they have a physical training test, where they are also expected to be back to their pre-pregnant weight. If they are not, they are referred to the dietician for six months. And then if they are still overweight they are discharged from the service.

There are some excellent advantages from being under the American system of care here, they are very much into preventative medicine; smear tests are done on all adult women annually, mammograms are first done at age 3? for a future reference, and then every two years from the age of 40, depending on the results, then a woman may even have mammos every year. Money is clearly no object here. What thi means for the expectant mothers is that every test imaginable is available. This of course can be both a disadvantage and an advantage, as tests such as the unpleasant test for diabetes which involves starving the expectant mother fc up to 12 hours, are automatically performed on all mums at 28 weeks. On the plus side, tests such as the AFP blood test are offered to all. But nobody is ever allowed to deliver here unle they also agree to an HIV test.

British mothers find the constant tests somewhat unnecessary in general, but some are reassured, and American mums positively expec everything.

There is of course also a higher caesarean rat (higher than UK, but lower than the USA) around 22%. American mothers find this encouraging but British mothers more concerned. There are no VBAC's, a breech is always a caesarean, but they do sometimes attempt to turn the baby. No mother ever seem to labour for much more than a day (unless she has strong objections to interventions).

But the greatest advantage I have experienced from working here is that I am able to see births. I have been present at four births so far; two caesareans and vaginal deliveries, and actin as a birth coach for one mother staying with he for eight hours while she was in labour.

Mothers are encouraged to spend the early hours of labour at home unless their membrane rupture. Once here, they have a standard half hour or so on the monitor. VE's (or pelvic exams as they call them here) are infrequent until the mother nears the end of the first stage but then may be every contraction. ARM appears standard at 6cm dilation. There are no restrictions on movement, or position during th first stage, a shower is available, and the only analgesic is Demerol, but they also use a pudendal block which at first I could not see th point of as mothers did not seem to gain any relief, then I read in an American obstetric book that a pudendal block allows an episiotomy to be performed. Episiotomy is common here especially on first deliveries as they do not like mothers to be long in the second stage, but the third stage is achieved without drugs unless ther are complications. Fathers are encouraged to cu

the cord, but then the baby is taken away for a standard observation on various monitors for the first hour or two, although if the mother is aware of this practise, she may discuss this in advance with the paediatrician and arrange for the monitoring to be done later. Few mothers either know or are concerned, although when I was teaching the antenatal classes I stressed the importance of bonding in the early hours and particularly encouraged mothers choosing to breastfeed to attempt to do so in the first hour.

Dissolving stitches are used, and witch hazel pads can be purchased to soothe as well as a sitz bath (a sort of mini bidet). Bathing is advised against until after the post-partum check.

Rooming-in is standard and breastfeeding is encouraged unless the baby is jaundiced. A pump is available, but the slightest rise in bilirubin is seen as potentially harmful and many mothers become discouraged. My attempts to change this policy failed.

In general I do not think that the care here is any worse than in a British hospital, in fact there are some advantages; here you get to see the person who is going to deliver your baby at every visit to the clinic. But having had a baby at home nothing else can compare. Although the practices here are different, I do find that Americans are extremely friendly and cheerful. We 'Brits' can sometimes be too serious about things.

All in all I am extremely grateful to the Americans to have such an opportunity to gain such experience.

Lynn Walcott
Jan 1993

NEPAL

A midwife in Nepal

Nepal is a country of great contrasts. When you lift your eyes up they are met with the beauty of the Himalayas that tower over the country. However, when you look around you are instantly aware of the poverty of a vast majority of the population. Hidden within this poverty are its own inequalities.

The inequalities that women in Nepal face begin right at the beginning of their lives. Nepal is said to have among the highest incidence of son preference in the world (UNICEF 1991). Sons are desired because they carry on the family name, represent and 'old age insurance' and because property is transmitted through them from one generation to the next. The midwife may get twice the reward if she delivers a mother of a son and at the naming ceremony five times as many things are prepared as offerings to the gods. Generally for baby boys the rituals surrounding birth, naming and the introduction of supplementary foods are more colourful and extravagant occasions than they are in the case of girls (Acharya 1981).

Out of every 1000 children born in Nepal 7 will die on their first day of life, an additional 16 by the end of the first week, another 30 by the end of the first month and another 54 by the end of the first year making an infant mortality rate of 107:1000 (UNICEF 1992). However, here again the inequalities are evident as both the infant and child mortality rates are higher for girls than boys (Singh 1989). This reflects right through to life expectation which is 53.52 for females and 54.88 for males.

Maternal mortality is another sensitive index of the status of women and girls and their access to health care. Nepal's high maternal mortality rate demonstrates among other things that women have a poor health status, the beginnings of which can be traced back to deprivation in girlhood. The official maternal mortality rate is 850:100,000, although some reports put rural areas twice as high. Girls are often fed less, taken to health facilities less, take on more of the workload in the household and so are often deprived of schooling. The female literacy rate is only 18%.

Burtibang Community Health Programme

I came to work in Nepal 18 months ago with a Christian non-governmental organisation called the International Nepal Fellowship. I am working with Burtibang Community Health Programme (BCHP). Burtibang is a village three days journey west of Pokhara, one day in a landrover followed by a 1½-2 day walk.

The programme puts emphasis on addressing these inequalities and states this in its aim: "To enable communities within the programme area to bring about significant improvements in their health. The programme aims to direct its work towards vulnerable groups of the society, including women, children and underprivileged communities and to work in such a way that health improvements are sustainable beyond the life of the programme."

The programme began in 1987 and plans to complete its work by the year 2000. The programme area includes a population of arour 70,000 people, 98% of them being subsistence farmers. The food they are able to grow is not sufficient for the whole year so the area is labelled by government as a food deficit area. There are no roads, so walking is the way to travel.

In what ways does the programme reach out to women, children and other disadvantaged groups? It has been shown that giving women the opportunity to become literate empowers them in many ways. Volunteers from each villag are chosen by the community to receive training from BCHP on how to run literacy classes. These facilitators then return to their village to teach others how to read and write. In 1992 492 people completed the seven month course; 424 were women.

I work with the health section. The first thing we do when we enter a new area is to encourage the formation of women's groups. By the time we begin our work many of the women will have completed the literacy classes and come with this new skill. Through these groups volunteers are chosen to receive training to become traditional midwives and village drug suppliers. Local mother and child health clinics are set up and run by these trained volunteers with support and oversight from the women's groups. One teacher from each school is trained as a school health teacher, they are then able to give health

The inequalities that women in Nepal face begin right at the beginning of their lives

education to the children. In turn school health clubs are then started to encourage the child-to-child method of spreading health messages among children.

Most of the health section's activities are aimed at preventative health care, but input is also given to support the local government health posts which are poorly staffed and equipped. Because our nearest hospital is three days walk away at Tansen we do get called to help out when emergencies occur.

Other activities that are offered to communities include water and sanitation, agriculture, animal health and income generating skills.

Midwifery Matters

As mentioned previously, because of our lack of curative health care facilities locally we do get called upon to help when emergencies occur, some of these obviously involve the use of my midwifery skills. I can't end without sharing just one of my experiences with you!

A few months ago a woman was carried quite a distance from her village to Burtibang. She had delivered her stillborn child seven days previously but the placenta was still undelivered. She was very sick, very anaemic and with a raging infection. Manual removal proved impossible as the cervix was only 1cm dilated. The family was very poor and refused to go to Tansen Hospital as they needed to get back home to look after the other children and tend the fields.

Eventually I decided to try using Syntocinon to see if this would dilate the cervix. Eight hours later the cervix was only 3cm. Another try using Valium and an analgesic proved fruitless. The family, sensing the gravity of the situation then decided they would go to Tansen. I was doubtful as to whether she would survive the journey, but we made her comfortable in a cut out basket in which the porter would carry her to the hospital.

She did survive the journey and after removal of the placenta seemed to recover well initially. Two days later abdominal swelling was noticed and a laparotomy was performed. The uterus had become necrotic where the placenta had been attached and a hysterectomy was needed. A quick recovery was made after this and she was then able to return to her family.

Sue Frame, Nepal, March 1993.

Sue Frame trained as a midwife at St. Mary's Hospital in London. After working in Tower Hamlets and Kent studied for the ADM at Surrey University before going to Nepal in 1991.

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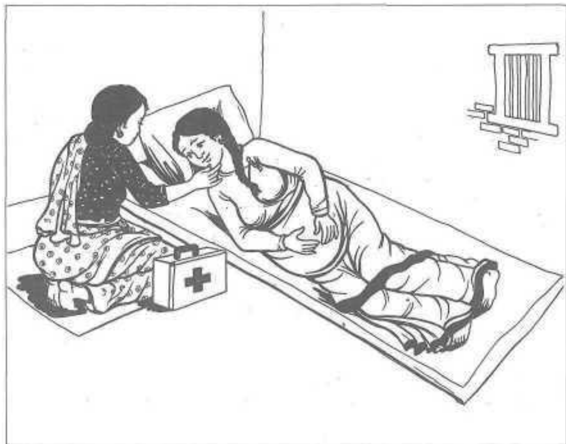


KENYA

Maternity Care in Kenya

It saddens me, having spent 2 years in a country which has one of the highest birth rates, appalling neonatal and maternal mortality rates, and AIDS spreading to epidemic levels, that my skills as a midwife have been largely wasted. The reason for this is long and complicated involving a bureaucratic & short sighted registration system.

In a small quiet way I have been able to help the local expatriate community who, although able to afford the best in health care available, find themselves without any of the benefits of midwifery care they could have got "at home". Birth is a functional process, augmented and interfered with in every possible way, private health care at its worst.

Postnatally, 4 hourly feeding bells, enforced segregation of all babies into the nursery are but two of the hurdles which new mothers have to overcome, alone.

Breastfeeding is encouraged to the point of enforcement, but who gives the advice, support and help needed? Certainly not the obstetric nurses who are badly trained and appallingly paid.

Mothers arrive home on day 3-4 (it's too expensive to stay in hospital any longer), with a new baby, sore and cracked nipples, painful episiotomy wound, (few, even multips, avoid the assault), and little or no support. As friends and family are usually "back-home", they are left to struggle and learn alone, using books as their guide, or local friends who all muddle along together as best they can.

Here I have been able to help, and in fairness have gained a lot from the satisfaction of knowing that I provide a service which no one else is able or willing to give. But how much better would I now feel if my skills had been challenged and used to their fullest in the past 2 years? What a crime to have a midwife sitting at home for long periods unable to work, in a country crying out for health care.

We're coming back to UK this year, no doubt I'll join the already swollen ranks of unemployed midwives – what a crazy world!

As you can see, this is all pretty negative. I'm looking forward to reading of other people's experiences overseas. I only hope they're better than mine!

Louise Hyde
Kenya
March 1993

ETHIOPIA

A midwife in Ethiopia

Women come to my home and know that they are welcome to bring their children, partners or friends.

For the past two years I have been providing independent antenatal care for women in Addis Ababa, Ethiopia. When I first came to live here my daughter was one year old and I was expecting a second child. It soon became clear that the only available option for antenatal care at that time was to attend one of the few private obstetric clinics or the outpatients at one of the city hospitals. Further enquiries revealed neither option to be attractive and I quickly decided to carry out self-care during my pregnancy, attending a clinic just once for a Hb reading, which was wildly inaccurate.

I was approached by several other pregnant women who asked me to care for them during their pregnancies. The appalling medical facilities, particularly for neonatal care meant that most ex-patriate women would remain in Ethiopia up until their 36th week of pregnancy, and then return to their home country for the delivery. During their pregnancies these women were expressing a desire for midwifery care in its fullest sense rather than the perfunctory 'Weight, Wee (if the reagents were available) and BP', the inevitable vaginal examination and some rather outmoded advice.

Before long I was receiving telephone calls from people I did not know asking for me to care for them, and I have now provided care for over thirty women in this situation. The care I have given has followed the typically British system of midwifery care. However these mothers have also had some very specific needs and I have placed particular importance on making them feel good about themselves and their pregnancies, particularly at a time that they are away from extended family and friends and may have particular concerns about being pregnant in a country with limited health care facilities.

The environment that I am able to provide is very relaxed, and appreciated by the mothers. They come to my home and know that they are welcome to bring their children, partners or friends. The first visit will be for at least an hour, I maintain a record book for myself and give the mother an antenatal record card to keep for herself. In addition to sphygmanometer, urine reagents and scales I have a sonic aid which the mothers (and fathers) really appreciate, especially as it may be difficult to obtain an ultrasound scan.

Invariably I form a very close relationship with the mother, and they know that they are welcome to call in or telephone me at any time. I have a large collection of books and videos on many different aspects of pregnancy which I lend out. When I have several mothers who are pregnant at the same time I try to arrange for them to get together for antenatal exercises, and have found 'The Ante Natal Tape' by Creative Film Producers to be very popular.

The mothers who have their pregnancies in Ethiopia do not have access to some of the tests that they might normally decide to undergo – for example AFP blood sampling or amniocentesis. Some women may decide that they wish to go abroad for these tests, whereas others opt just to accept what can be offered locally. There are laboratories where Hb, blood group, VDRL, etc., can be safely tested.

Most of the women I have cared for have really enjoyed their pregnancies in Ethiopia and have been extremely fit and well, thankful to be spared the disjointed and time-consuming medicalised model of maternity care that would otherwise be their lot in their home countries. I have cared for several American and German women for whom my first explanation has been "What is a midwife....." with the helpful assistance of the leaflet of the same name.

There are certain considerations which are specific to these women. Areas outside Addis Ababa have a high risk of malaria, and women are advised to follow the regime of Chloroquine 2 weekly and Paludrine 2 daily when travelling out of the capital, as it is more dangerous for a pregnant woman and her child to get malaria than to take the phrophylatics – the most important measure is to try not to get bitten by mosquitoes after dusk.

Many of the mothers I have cared for have had a difficult time maintaining their morale and confidence when family and friends tell them that they are mad to stay in Ethiopia during their pregnancies. This is something we will talk about at great length, the bottom line always being that the woman and her partner must make their own informed choice bearing in mind their own circumstances. They are the only ones who have to live with or like their decision. I am a great believer that a confident and contented mother will be the most likely to have a straightforward pregnancy and delivery and having made their decision these mothers know that they will have my absolute support, and that we will cope with each situation as it arises.

For all the women to decide to stay until the 36th week of pregnancy (most international airlines will accept them until this time with a supporting letter stating their EDD) there is a very difficult time during the last few weeks when they know that a child born prematurely in their home country would stand a very good chance of survival, whereas in Ethiopia survival before 34 weeks is unusual. Incubators are shared, oxygen not measured and ventilators non-existent. A rather philosophical approach is usually reached, and thankfully I have not yet encountered this situation.

Several of the mothers I have cared for have suffered miscarriages or missed abortions. I have been able to arrange for necessary ERPC locally, or else medical evaluation to Nairobi. If problems do arise during pregnancy I have contacts with several local obstetricians who have been tremendously supportive and helpful. Unfortunately if a mother does have to go to a hospital for any reason they are invariably distressed by the dirty and distressing conditions that they find.

Some mothers will decide to have their babies here in Ethiopia, although this goes against the policy of most of the government or international organisations for which most are employed. The prospect of being separated from their partner and possibly other children for a long period of time may be unacceptable. Additionally many may no longer have a home to which they can return.

I have known mothers to deliver their babies in the local public hospitals. This is very much a matter of grin and bear it, with a complete lack of privacy, analgesia or proper care. Husbands are not allowed to be present. There is the ever present risk of infection. Standard procedure is for the mother to be lain flat on her back, IVI in progress and routine episiotomy.

Two mothers have requested home births. Whereas I have fully supported this wish, I have felt that I personally did not have sufficient experience to undertake this on my own, particularly as there is no-one to come to your assistance if things go wrong. However I was able to enlist the help of another very experienced German midwife who has been working in a health centre in Ethiopia for the past 20 years.

For one mother it was her second child, she spent most of her labour in the garden and the delivery was straightforward. The second delivery I attended was a particularly joyful and memorable occasion. For the mother it was her fourth child and her pregnancy had been a difficult time with no congratulations, only mutterings about "why another one", and especially "you must be mad to have the baby here".

When she went into labour her other three children all came home from school and immediately gathered expectantly in her bedroom, only to be told that it would be several hours yet! The mother bathed, I massaged her with oil, she walked around and finally after a short second stage John was born in the midst of his family, to a chorus ten minutes later of happy birthday and "thank you Lord" from my colleague. It would not be true to say that we had no worries, but we had made every possible contingency plan in the event of problems (transport, obstetrician and paediatrician standing by at hospital) and there were no particular risk factors. For the family an occasion of absolute joy and peace.

The prospect of being separated from their partner and children may be unacceptable.

Support & care for women by midwives is needed & appreciated all over the world

This is an environment in which mothers feel very comfortable and natural breastfeeding, in fact of about forty new mothers I have known all have started breastfeeding and nearly all have continued for many months. Between a group of us we run a mother and baby/toddler group. Apart from friendship this provides tremendous support, especially for first time mothers who do not have any of the traditional sources (their own mother, health visitors) to turn to. It is quite fascinating the different cultural ideas that exist between us all. Quite often a great deal of harmful advice has already been given to the mother in the four or six weeks following the birth of their baby and before their return to Ethiopia. In particular regimented and discredited ideas about breastfeeding, but suddenly here everyone is doing it all the time and the problems seem to get so much less!

I do hope that other midwives reading this may think about using their midwifery skills if they go to live abroad, even if they do not work within the existing health services in that country. Support and care for women by midwives is needed and appreciated all over the world, and never more than by women who are otherwise very much on their own.

Sarah Holmes, RGN, RM
Addis Ababa
January 1993

A personal tribute to Elaine Ho: Elaine was my own midwifery tutor and it was from her that I truly came to appreciate the importance of the midwife and her partnership with the women she cares for.

HUNGARY

Natural birth centres in Hungary

Agnes Geréb, *MD, an Obstetrician/Gynaecologist and psychologist in Szeged, Hungary, has written to ARM with information of a proposed natural birth centre, "ALTERNATAL", which aims to "unite prenatal care, delivery and postnatal care in the same spot". Although her letter was an appeal for assistance, mainly of a financial nature and perhaps partnership, which ARM is unable to take on, the supporting information was sufficiently interesting to be shared with our readers. Who knows, someone out there may be able to respond to the request for help.*

Brief CV., Background and History of the Project.

I have been practising as an Ob-Gyn since 1977. From the very beginning of my career I made efforts to avoid harmful effects of medicalised birth also by using in this my studies in the field of psychology. I also committed myself to improve my knowledge in the field of natural birth and managed to study for this reason home birth in the USA in 1990.

Though my efforts with my own patients in Hungary were successful, the new concept did not spread as I thought it should. The obstacle in the way of progressive change was not only the well-known professional approach, but it also came from and is deeply rooted in the communist system and its effect on the human psyche.

So, it was not by accident that after the change of the political system, rather slowly though, a change of mentality came by. We can see a shift in people's behaviour, more and more people dare to name and claim their natural human needs including the need for natural birth process.

This movement led me to organize an international conference on childbirth in Szeged in 1992. I also published a book in Hungary on the topic of home birth.

As a result of the conference I found partners for my goals: Kate and Gábor Donján, a couple who can and are ready to realize my project. They, themselves having six children, are devoted supporters of the case. Forming a team with them, we have recently founded the fund *Alternatal* to promote the acceptance and spreading of gentle, natural birth.

As a result of the conference in Szeged, many articles have appeared recently in the press about home birth and also the topic of natural birth was aired through a widely seen program of the national television when they broadcast an interview with me not very long ago.

As a conclusion there is now a very sharply rising interest in Hungary amongst would-be mothers for less medicalised birthing methods.

Unfortunately, however, the opinion of the Professional Committee is quite negative about home birth, (or as a matter of fact about anything other than hospitalisation), the only improvement they believe to be apt in order "to humanise birth" is to let fathers be present and create more facilities for rooming-in.

Luckily, there is a way out from this far too "conservative" approach. A new law which was accepted by the parliament just a few months ago and which regulates the system of prenatal maternity care opens up new possibilities for many projects, including family planning, prenatal consulting, etc. By taking part in these

programs there is a chance to achieve a change towards the acceptance of natural birth.

Our project is based on this possibility. The institute we are to establish would be a gynaecological and obstetrical clinic and also a prenatal care centre, where pregnant women and their families apart from special and general check-ups could choose according to their demand from a wide range of possibilities. They could read literature in the topic, they could meet with the Ob-Gyn, paediatrician, midwife, psychologist, physiotherapist, etc. By the participation of doctors, midwives, nurses and social workers we would also like to make our institute a centre of postgraduate studies for them in the field of natural birth.

As for birth, we would accept willing mothers for the delivery in our institute only if there is no indication at all for sending them to hospital.

The ideal setup to establish our institute would be to work together with a reputable partner institute from abroad. This would give us more freedom by avoiding the supervision of the very strictly hospital-oriented and conservative minded Professional Committee, and also could result in getting better term government loans for the project.

Though our project might seem risky because of the resistance of professional circles, it is worth knowing that there is also enough encouragement for us to go on, even from within the Ministry of Health, too. There are also different movements and groups in the country who are willing to and can have beneficial influence for our case.

We are also negotiating with the National Health Insurance Institute and they seem to be ready to pay the expenses of our patients in the future. They accept that due to the lack of need of hospitalisation after natural childbirth it would be an expense-saving investment for them. However, because the NHS of Hungary is a very inefficiently working inheritance of the communist era the whole Insurance system is undergoing a slow re-regulation process now in parliament. The final settling will very likely take about a year or two. Until then our patients will have to cover all their expenses unless they have special private health insurance policies, which is relatively rare nowadays in Hungary. This has to be taken into consideration when investment and feasibility is studied.

We already own a piece of land for the purpose (approx. 2 acres, value approx. £83,000). It is on a gently sloping hillside surrounded by forests in a nice garden suburb on the outskirts of Budapest – an ideal place for a recreational centre.

The proposed building will be a two storey house which could accommodate 4 deliveries at any one time. There will be a large room for group sessions on the upper floor, and a separate flat for the caretaker. About one third of the price of the full construction works (approx. £250,000) can be covered by our own resources.

Equipment and instruments will be important items, though some of these are unnecessary but expensive items which are a requirement for licensing of the institute. Inexpensive second hand items, and donated equipment would help to satisfy these official requirements.

We are planning a staff of 20 people, including 4 full-time and 2 part-time doctors, (Hungarian laws at present demand the presence of an Ob-Gyn at the birth), 6 full time midwives, plus various other support staff. The staff would be relatively well-paid (e.g. £10,000 p.a. for a doctor's salary, which is 10 times the officially accepted minimum wage). In this way we hope to change habits – in the NHS hospital doctors are badly underpaid, so that although medical care is free of charge in theory, it is practically "compulsory" to tip them very highly – a very corruptive practice.

We calculate the cost of a nine month prenatal care program including the delivery itself would be approx. £500 per woman. To compare with other private practice in Hungary, a face-lift costs £830 to the patient. This suggests that our price would be rather low. However, knowing the present day economic state of the country, and bearing in mind the average family budget, it is about the maximum we can ask at the moment, without making our institute very exclusive, and accordingly losing the vast majority of our possible clientele.

The four birth-room institute is planned to accommodate an average of 2 births per day, around 700 per year. Thus the expected annual income would be £350,000, less the expenditure of wages and other items, say £250,000 would yield a profit of £100,000 to service the loans and other investments. We expect the institute to be able to work profitably after a short period of time.

We believe that on top of this, the real profit for our partner institute would be that they could be present in starting a movement, a change of way of thinking, which we hope is likely to culminate in a network of natural birth centres all over the once so-called socialist countries. Thus the partner institute could be able to reach may hundreds of millions of people in the long run.

Thank you for studying and considering our proposal.

Agnes Geréb,
Szeged,
Alföldi u. 3,
H-6722, Hungary

More and more people (women) dare to claim their need for natural birth.

Note from Ishbel

Agnes also enclosed some architectural plans of the proposed building, which may not reproduce very well for *Midwifery Matters*. I replied to her letter, regretting that we cannot help on the scale she is seeking, but that I would tell our members about *Alternatal*, in the hope that individual offers of help, equipment, services, etc. would result.

A foreigner's perspective

Penni Bestic

Of the 1,340,660 babies born in Japan in 1986, my son, James, was one of the 1,247 babies born at home that year. Mizuochi was the name of the midwife we chose to attend his birth, she being referred to us by an obstetrician and professor of midwifery as being a much respected and knowledgeable midwife of many years experience and births – over 7,000.

There were approximately 25,528 registered midwives in Japan in the late 1980's with a few maintaining to the more traditional midwifery model of care. Working from their homes – which were usually three storied buildings or a cluster of small buildings, they live with their families, often on the third floor, with the second floor often used for labour delivery and post-partum stay rooms, while the ground/first floor rooms are used for antenatal checks, post-partum groups, and the kitchen. There are variations on this theme. Clinics visited were often in crowded areas, being an established part of the neighbourhood. Large signs outside the clinics, just like any other business, make them easy to locate, but if the maze of narrow congested streets did prove disorientating there was always someone to point me in the right direction.

Food during labour has always been encouraged in midwives' practises to provide energy for the uterine muscle's work

Mizuochi utilized her small traditional Japanese garden – situated in a north-eastern suburb of Tokyo, her home/clinic with its old pond and bright orange and gold carp, viewed as they swam, from the traditional large tatami (straw mat) room, would have been a lovely area to labour and give birth in. I wanted to give birth at home, and Mizuochi at first tried to dissuade me from it, as we lived far away from her across the other side of Tokyo. Most midwives prefer to work from their own homes/ clinics – not working in pairs, they are often needed to attend more than one mother at a time. I visited a midwife in private practise near my home on a public holiday during 'Golden Week' (a week of 5-6, national holidays) – and attended three births in a six hour period.

Some hospitals cite rates of up to 80% of births being midwife attended. The maternal and child health statistics for 1986 cited a rate of 2.8% of all births, being attended by the midwives in private practise either at their own clinics or in the mother's home.

Mizuochi was one of the dozen or so midwives *in private practise in Tokyo. Like the majority of* them she was in her late 60's. It is hoped that the new group of midwives now starting up practise in Tokyo, for example, will prevent the present 2-3% midwife managed births to become an ever lower percentage, as the present, older group of midwives reach retiring age. They may be working for a few years yet, though. One of the ten midwives practising in Kyoto in the late 1980's retired at the age of 83! There appear to be a small number of older midwives still working in a consultant capacity – being called into a younger midwife's practise for difficult births.

In 1950, 90% of the 2,586,000 births were attended by midwives. The midwives then were an established part of the daily community life, occasionally being acknowledged in the art forms of Japan, such as this example in a form of Japanese poetry – a 17 syllable poem – 'haiku'.

"Maple leaves in Autumn,
the colour of
midwives' hands."
Anonymous (16th century?)

Mizuochi like many of the midwives in private practise came to set up practice because of a dissatisfaction over what was occurring in the management of birth in hospital. After the American occupation of Japan, in 1948, the way of birth became Americanized, with routine lithotomy position, more often than not an episiotomy, and separation of mother and baby becoming established routines in obstetric hospitals. Yet, these are the preferred places of birth nowadays, especially by the grandparents who view these institutions as superior to the midwife's practise and clinic.

The Japanese, as in all their adoptions of things foreign, chose to adapt it to their unique cultural preferences, they didn't give up eating during labour for example. The use of food during labour has always been encouraged in midwives' practises to provide energy for the uterine muscle's work. Administration of pharmaceutical pain relief even today remains minimal – it is just not readily available with the belief that it may harm the baby.

An American woman delivering in a prestigious obstetrician's private clinic in Tokyo, where antenatal checks, normal delivery and five day post-partum stay costs 6,000 dollars (US), requested pain relief. The midwife assured her and went off – to get the hoped-for pain relief, but returned with two hot water bottles – which were said to be very helpful, after all – despite the initial disappointment. They were tied on and secured, lying over the lower abdomen and back.

The 'baby-friendly' attitude of no drugs, continues on into the early parenting with mothers sleeping, bathing and weaning their babies for many months, sometimes years, continues in family life in modern apartments. Breastfeeding is considered the norm, but with current aggressive marketing from formula companies, and Western management of breastfeeding, such as restricting time at the breast and feeding every four hours to schedule; many mothers claim not to have enough milk – only 59% were fully breastfeeding at 3-4 weeks in 1985. Pregnant women are heard to say they would like to breastfeed – if there was enough milk.

Sugiyama, a midwife in her 50's, with a busy practise – 15 minutes by train from downtown Tokyo, sees her work in the community as being valuable. With the introduction of the nuclear family, the kinship ties that come through giving birth locally and naturally, she feels, enhances the community feeling that where natural birth occurs, the natural ties of the community life are deepened.

Most of the midwives in private practise are members of the Japan Midwives Association, claiming a membership of 10,000. Its members come from both hospital and private practise midwives. They are a politically strong group.

Most of the remainder belong to the Japan Nursing Association, the group that hosted the 22nd International Midwives Congress, in Kobe, Japan in 1990.

The midwives in private practise can only set up practise with a professional liaison/assistance of a nearby obstetrician and his clinic. The closest receiving hospital in emergencies, is usually a large training hospital. The need to transfer, or to call for obstetric help, is a rare event. This could be because, not only are the midwives skilled, well equipped, and well trained. The mothers to be themselves are very diligent about their babies' well-being. I think it will be many years before Japanese women will be seen smoking when pregnant. Careful screening of potential clients is also performed – Mizuochi, only took on 80% of the women who came to her for care, for example.

A traditional diet is encouraged during pregnancy – very similar to a macrobiotic diet, except it includes fish, and comprises the traditional rice, (usually white these days, only one I knew served brown rice), vegetables and seaweeds, and tofu. After birth the woman always enjoys delicious home cooking from the kitchen in the midwife's clinic. There are usually one or two women helping with the household duties. When my midwife visited me at home on the fourth day post-partum – a two hour trip one way – she brought food for my family and I.

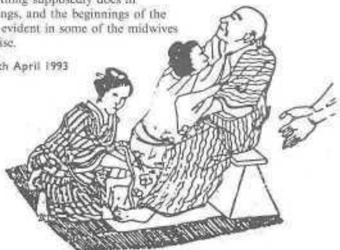
Many of the traditional ways remain in most midwives' clinics, not only with the food served but the pregnancy and after birth customs. For example the wearing of the 'iwate obi' – belly band worn from the fifth month at the time of quickening, continues to be worn by the mother to be even in the 1990's. The traditional belly band is a five metre long white sash, with auspicious sayings written on it, that is wrapped around the abdomen – most women today wear a modified version. It is believed to keep the 'hara' – lower abdomen – a revered part on the Japanese body, warm; others believe it keeps the baby in a good position for birth, while another thought is that it provides comforting support for the mother. It is considered auspicious to purchase it at the specially assigned temple for easy births, on the Day of the Dog – because dogs have easy births.

James was born on a snowy night, in February – while the midwife's taxi waited outside! She had come, bringing a much appreciated female attendant. He was born in the age old way of kneeling and hanging on to a support. This has been a common birth position for the past 2000 years in Japan. A rope over the farmhouse rafters was often utilized, or grasping a wooden beam either in the tokonama (decorative alcove) or on the verandah. During the past 20-70 years with the lithotomy position being adopted for bearing down, in some clinics parturient women have been encouraged to hang on to the rails at the back of the bed, and occasionally for the 20% partner attended births, support is encouraged by 'hanging on' to the partner's neck while bearing down.

Two hotwater bottles were secured over the lower abdomen and back

Even with the re-introduction of an active birth in the 1980's – in the 1990's it is still being used in a minimal way, but could increase as without pharmaceutical pain relief women could get up off their backs – yet such a move is not part of the majority of Japanese females' make-up at present. It may be a slow move to go full cycle – as everything supposedly does in Buddhist teachings, and the beginnings of the move are more evident in some of the midwives in private practise.

Julie Pearse, 9th April 1993



CANADA

Birth of a profession

"How remarkable this actually is, that we are finally moving to a point in time where we will have legalized midwifery in this province and show leadership in Canada in terms of establishing the practice of midwifery and the support for that profession. I think of it myself in personal terms as a young woman who has yet to have her first child. I hope I will have that opportunity in my life and I hope I will be able to have that opportunity to choose to have a child in my home with the assistance of a midwife. I am thrilled that that prospect may become a reality for me and for many other women in this province."

Frances Lankin, *Minister of Health.*

Midwife Judy Rogers weighs Cody Steele after birth at home while his sister Jessica looks on.

This statement was made in the Legislative Assembly of Ontario on the second reading of the Midwifery Act, 1991. Ontario is the first province in Canada to legalize midwifery and it is indeed a historic step.

Health care in Canada is provided on a socalized model but is organized provincially, not nationally. Each province is responsible for health care legislation and funding subject to broad federal guidelines regarding universal access to services, etc..

Midwives have been attending births in Ontario since 1975 in response to women's need for alternatives to the often highly medicalized model of birth that is the norm here. Traditional maternity care has included a range of institutional options from small cottage hospitals where women are attended in delivery by their GP's, to large urban teaching hospitals with epidural rates in excess of 90%. Women have been able to receive care from either GP's who are doing obstetrics or obstetricians.

No Legal Status

Until this year, midwives have been working in an 'alegal' context in Ontario. That is, there has been no legislation to recognize midwifery, and the province has not chosen to prosecute any midwives for practising medicine without a licence. However, midwives have been subject to inquests when neonatal mortalities have occurred and there has always been the possibility of criminal prosecution. Needless to say, this has meant that midwives who practice here are deeply committed to their chosen work and the families they serve.

The Association of Ontario Midwives (AOM) was formed in 1984 and is a voluntary organization which has set standards of practice and educational requirements for members. Midwives in Ontario have a variety of educational backgrounds, some with foreign credentials and some with apprenticeship education. Many of the apprentice-trained midwives have worked as midwives under supervision in maternity hospitals, birthing clinics, and with community-based midwives in Texas, Jamaica, and Holland, in addition to lengthy academic and clinical experience in Ontario.

Much of the work towards legislation has been done by the AOM and a consumer group called the Midwifery Task Force (MTF). This has truly been a joint effort of women and midwives to create major social change. Women chose to give birth with midwives because they didn't want the available medical options. Midwives had the courage and strength to support them. And together their immense political work is changing the face of maternity care forever in this province and hopefully in the whole of Canada.

Model of Practice

Midwives here work much like independent midwives in Britain. We provide continuity of care and most of us work in small group practices of 3-6 midwives. Some midwives work on their own in more isolated areas or with another midwife for back-up. About 60% of the clients in my practice are planned home births and 40% hospital births. Midwives are the primary caregivers at home births, but until the legislative changes are complete we will not have hospital privileges to enable us to conduct deliveries in hospital. We are expecting these

changes in the autumn of this year but until then we usually labour with women at home until they are 7-8cm and then accompany them into hospital as their advocate and support person.

In my practice the care for each woman is shared between two midwives, a primary and a back-up. We provide antenatal care alternating visits between us, and the primary midwife is first-on-call for that woman in labour. In a planned home birth the back-up midwife will be called in advanced labour so that two midwives are present for the delivery. In a planned hospital birth the primary midwife will be going into hospital with the woman usually at about the same time and will be liaising with the woman's doctor. Midwives are the only caregivers who provide postnatal care in the community and most of our clients go home from hospital within 4-12 hours after delivery. We see women at least on Day 1, 3 and 5 or 6, with telephone calls in between and more visits if needed. We also visit at least once in the second week and have the mother and baby come to our clinic at 3 and 6 weeks postpartum. Primips usually need more visits in the first two postpartum weeks than mutliparous women, and these are often shared between the two midwives.

Because midwifery has not been a recognized part of the Ontario health care system, the cost has not been covered and clients have had to pay midwives directly for their services. In order to try and make it accessible to as many people as possible, many midwives charge on a sliding scale according to family income. Fees range from £250 to £750 for a full course of care. As part of the legislative recognition of midwifery and the integration of midwifery care into the health care service, the government has committed to funding midwifery care by the end of 1993. Negotiations are currently underway to determine the method of funding.

Disquiet about Legalization

Not all midwives currently practising in Ontario are happy with the move towards legislation. Some see it as a potential loss of the grassroots movement, a 'professionalization' that will end up being as self-serving as the medical community. Much of that depends of course, on the midwifery model of care that is developed, as well as on the method of funding midwifery care and the model of education that is developed for training midwives of the future. Midwives through the AOM and consumers through the MTF continue to work hard in all these areas.

The Ontario government appointed an Interim Regulatory Council on Midwifery (IRCM) in 1989 to lay the foundations for the regulation of midwifery. They took the work of the AOM and further developed it to create a Philosophy of Midwifery Care in Ontario, Code of Ethics, Core Competencies, Midwives' Pharmacopoeia, Indications for Mandatory Consultation and Transfer of Care, Indications for Planned Place of Birth, and many other useful documents.

Their work is now being taken over by a Transitional Council of the Ontario College of Midwives which will ultimately be replaced by elected midwives and appointed consumers. The Philosophy of Midwifery Care in Ontario is a remarkable document. It enshrines continuity of care, choice of birthplace, and informed choice as essential components of midwifery care in Ontario.

Currently practising midwives have been undergoing a year long Pre-Registration Program in order to be assessed for academic and clinical competence. Midwifery faculty were hired from Denmark, Holland, England and Australia to undertake this challenging task. Midwives who successfully complete this program will be eligible to apply for registration with the Transitional Council once the Midwifery Act is proclaimed.

Women chose to give birth with midwives because they didn't want the available options.

Midwifery Education

A baccalaureate program in midwifery is being established among three universities in Ontario. It will be offered from September 1993 and will be a four year program to be completed in three calendar years to enable midwifery students to follow women clinically. Course design is still underway but it has been recommended that students spend a minimum of 50% of their time on clinical placement in community practices. Midwifery faculty will be required to maintain clinical practices half time and all teaching will be job-shared. It's an exciting model in which I hope to participate.

Future Possibilities

If any of you are thinking of emigrating in order to work as midwives in Ontario, I must tell you it will not be easy. There is an understandable desire to protect the model of midwifery as it is currently practised here. I have sent Ishbel information from the IRCM on registration of midwives which may answer many of your questions. Enquiries should be addressed to the:

Transitional Council of the College of Midwives
PO Box 2213, Station P, Suite 285
Toronto, Ontario M5S 2T2
Canada
Tel. 416-658-8715 Fax 416-658-9532
Or contact Ishbel Kargar. Tel. 0695 572776

Midwives had the courage to support them.

This truly is a monumental time in history here in Ontario and in Canada. I am filled with respect for the midwives and women who have worked tirelessly for more than a decade to achieve this impressive goal. The work goes on of course and much effort is still needed to ensure that the pieces fit together to protect the midwifery model of care in the future. Certainly those of you in ARM know all about that.

With love and in sisterhood always,

Judy Rogers.
Ontario

Journal – "Health Care for Women International"

BUSINESS

The above journal is among the many publications received by ARM on an "exchange journals" basis. It is published in USA, edited by Phyllis Noerager Stern, DNS, RN, FAAN, Professor and Chair, Parent-child Department, Indiana University School of Nursing, with 13 Associate Editors and a long list of reviewers in many other countries.

The Aims and Scope are described as follows:

"Health Care for Women International provides an international, interdisciplinary approach to health care for women, and consists of research reports and clinical and theoretical papers about a wide variety of women's health issues. We welcome manuscripts on general women's health, obstetrics, gynaecology, perinatal and neonatal care, problems of aging, alternative life-styles, cultural differences; and phsycological challenges. We accept papers that discuss the newest theories, skills, procedures and issues in the health, psychology, sociology, anthropology and nursing professions."

Sally Herbert has prepared a summary of items relevant to maternity care, starting with the first issue we received in 1985, and has undertaken to up-date the list periodically. If you would like a copy of this summary, please write to me, and I will photocopy the relevant pages for you, at a cost of 5p per page, plus postage.

Ishbel Kargar
(Secretary)

Audit of Independent Midwifery practice

In October 1991 The Department of Health approached the Independent Midwives Association to prepare an audit of independent midwifery practice from 1980-1992. The period was chosen in order to get a broad range of practice and cover a minimum of 1000 cases. The project was funded by a grant from the Department of Health, administered by the Royal College of Midwives, and the research was undertaken by Melody Weig.

Melody wrote to all the midwives known to have worked independently during that period, asking for their assistance in providing data for the research. All midwives taking part were given full details of the aims, the background and the organisation of the audit.

The aims were twofold.

First, to carry out a limited retrospective review of specific data items found within birth registers and individual case notes in order to audit specific client characteristics, processes and outcomes associated with independent midwifery practice. Second, to write a report of the findings for the Department of Health.

A Steering Committee was formed to oversee the project, consisting of Joan Greenwood (DoH), Alison Macfarlane (NPEU), Julia Alison (RCM), Cathy McCormick (RCM), and Jill Demilew (IMA).

43 independent midwives took part in the audit, submitting copies of birth registers, (and in some cases copies of case notes), of deliveries at which they had been prime midwife. These concerned 1,285 women from 1980 to 1991. Comparisons were made between data from the audit and data from other studies of maternity care, both within UK and overseas.

On completion of the research, the Report of the audit was written and submitted to the Department of Health early in 1993.

We congratulate Melody on the tremendous effort which she put into this project, involving as it did an enormous amount of work and a great deal of personal commitment over a long period, while maintaining her own midwifery practice and caring for her family.

Many changes are now taking place in the provision of maternity services, impelled by the formation of Trusts, and following the Winterton Report. The Report of the Audit of Independent Midwifery Practice from 1980 to 1991 will add to the valuable information needed by those involved in planning and implementing changes in maternity service provision, particularly such innovations as midwifery-led care and team midwifery. For this reason it is hoped that the Department of Health will expedite the review process in order to publish the Report as soon as possible.

Report of the Spring National Meeting 20th March 1993

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Held at the Kings Heath Community Centre, Birmingham

Over 40 people attended the meeting. We began the day as usual with each person giving a short personal introduction. Soo Downe chaired the morning session of discussion on various topics.

Income support for 18-24 year old pregnant women

Ishbel reported that RCM has launched a "Mothers Day" campaign to have the level of income support for this group raised from £33.60 per week to the adult rate of £42.50, and are seeking all MPs support for the Early Day Motion no. 1580. Sample letters were distributed, which members were asked to send to their own MPs, (or even better, write their own), urging the MP to support the EDM.

International Confederation of Midwives

1. Olga Parker asked for anyone planning to go to the ICM Congress in Vancouver to get in touch with her, so that a mini ARM meeting can be arranged during the Congress.
2. Our two elected delegates to ICM Council are Soo Downe and Caroline Flint. However, Caroline is unable to attend the Council meeting this time, and is standing down. We obtained agreement from ICM that we could send someone else in her place. As there was no time for a formal election of this replacement, and Olga Parker had consistently attended ICM meetings for many years, having expressed her interest to be nominated when a vacancy arose, the Steering Group agreed that she should take Caroline's place in Vancouver. She will ask for ratification of this at the AGM in September.
3. ICM has confirmed Observer status for our nominees, Patricia Rouse and Mary White. This enables them to attend the ICM Council meetings, which take place during the week before the Congress, and ensures that we have people familiar with Councils proceedings, as possible future delegates.

Choices in Childbirth Leaflet

A few months ago this leaflet went out of stock so Ishbel asked for assistance in preparing a new edition bringing it up to date with the current options, and a small group of Steering Group members took this on. Although we did consider having it re-designed, with illustrations, there was some urgency, as Ishbel was having to photocopy the old leaflet, so she has had 1000 of the new edition printed, giving us time to consider an illustrated edition. (Hilary Mathieu has obtained some rather nice illustrations which we could use). Unfortunately some minor changes were received after the printing had started, but these can be made at the next re-print. (The leaflet is popular, so it won't take too long!).

Consensus Conference (4-5th March)

This report was given by Soo Downe. ARM had been invited, at short notice, by Baroness Cumberlege to send two delegates to this two day conference, (4-5 March). Its aim was to "promote debate about important and controversial issues and for a panel to produce a consensus statement, based on contributions from speakers and the audience, on the issues addressed". The statement prepared by the panel following the conference would be used by the Expert Group chaired by Julia Cumberlege.

Soo Downe and Mary Cronk were chosen by a hurried "straw poll" to attend on our behalf. Soo explained that the panel, which was chaired by Niall Dickson (BBC) consisted of eleven people representing maternity care professions, consumers, purchasers and providers of maternity care as well as representatives of black and ethnic minorities.

A number of invited speakers addressed the issues, basically about choice and continuity, and after each set the invited audience, (about 300 people), then had a chance to question the speakers. The panel did not ask many questions, they were really trying to get the feeling of the meeting.

Soo said that there was a clear divide between the medical view and the midwifery view, but there was more common ground than she had expected. She thought the lay members of the panel must have cringed at some of the statements being made and the professional antagonism between various groups. Also the medical people showed a great deal of non-research based thinking.

Soo and Mary had each received a copy of the statement, which is a 17 page document, not much different from the Winterton Report according to Soo, but she quoted two significant paragraphs from the document:

"However, it is not clear from the evidence just how important, in itself, continuity of care is for most women. Although studies have shown that women believe it is desirable, they do not

necessarily rank it as highly as, for example, having a safe delivery or receiving consistent advice. In practice, though, one of the most effective ways of achieving such consistency will be to reduce the number of professional staff involved in the care of each woman and to ensure that they work together as a team. For most women the midwife will be the key professional in providing continuity and, given the preference of many women for community based antenatal care, the aim should be to reorientate services so that midwives can follow women throughout and beyond their pregnancies. However, the provision of continuity of carer is not exclusive to any one group".

Soo commented that this last sentence was highly significant.

The second important paragraph is "Greater emphasis on midwifery as the profession most likely to provide continuity of care to the majority of women may have an impact on the systems of remuneration both for GPs and midwives." This is reflected in one of the recommendations made by the panel: "At National Level – We recommend that the Government should...... develop new payment criteria for GP, hospital, midwifery and community services which will encourage more appropriate patterns of care".

UKCC elections

Three of the five candidates supported by ARM's election campaign posters had been elected to UKCC, Mary Cronk and Sarah Roch for England, and Alison Scoullar for Wales. We congratulated these people, and Ishbel read out their "thank-you" letters.

Soo reminded us all that we should support our elected members of UKCC, and keep them aware of issues which we feel should be addressed at that level. She gave the example of supervision, and the fact that there is no appeal mechanism for rebuttal of unjustified accusations by supervisors, unless the case goes into the disciplinary procedure.

Midwifery Matters

Concerning the new journal, the first issue under the new contract, Sandra told the meeting that it has been very hard work, but that she was delighted with the end product, although there were still a few minor alterations to be made. The paper was much heavier than previously, which had resulted in an extra £180 in postage for the bulk mailing, plus higher on-going postal costs whenever this issue is posted out. Sandra told us that these points have been accepted. Most of the comments received had been complimentary. She hoped that eventually *Midwifery Matters* will be seen on more library shelves, and that it would carry more referenced articles. This initial issue cost almost £4,000 for 2,000 copies, but approx. £900 of this is a one-off payment for designing, illustrating and setting up etc. The company, *Argraff*, accepted our stipulation that £3000 per issue, including delivery to Ormksirk, is our budget ceiling.

We had a short discussion on the comparative costs of illustration by line drawing as opposed to photographs. Sandra said that although drawings were cheaper to produce, they need to be in clear black outlines, with minimum of shading. *Argraff* have a comprehensive library of photographs which can be used, or they can process our pictures, but these must be suitable. The cost of reproducing photographs varies with the size, but averages £15-20.

The subject of recycled paper came up, and Sandra told us that future issues will carry a statement that we are using "environmentally friendly" paper. It was agreed that recent improvements in paper manufacture make this less obvious than before.

Sandra asked for volunteers to "referee" certain articles which deal with issues which may not be very familiar to the majority of us. This is to ensure the quality of the information

The ARM roadshow

Sally had set up the display stand which ARM has bought, to show members who had not been at the Cambridge meeting. She gave a short explanation of the purpose of the Roadshow, which is to raise the awareness of ARM, our

aims, our work, etc. around the country. At the AGM ARM agreed to fund a one year trial of the project. Sally will respond to requests from individual members, groups, other organisations, etc. to visit their unit, and set up the display perhaps in the Antenatal Clinic during the day, with a supply of free leaflets, (ARM info. and "What is a Midwife?"), and attend a meeting, perhaps during the day or in the evening. This may be to support a campaign against closure of local unit, to encourage local awareness of topical issues, or just to increase local membership. The field is wide open.

It has to be explained that Ishbel has for some time been taking an ARM stall to various study days, conferences, etc., but recently has had to reduce these, due to pressure of work. Having Sally's hours available means that more of these events can be covered, in addition to the original purpose of the Roadshow. In January Sally and Ishbel took the display to the Conference on "Midwifery-Led Care" at the Royal College of Physicians in Edinburgh, which was a very useful visit. There are several advance bookings, spreading well into the Autumn. She is aiming to average one or two trips each month, and is hoping that the results will be apparent in increased membership and sales of ARM goods and leaflets.

Sally said there is no cost to the Local ARM Group booking a visit from the Roadshow. Their only responsibility is to provide a venue, possibly refreshments, and when necessary overnight accommodation for Sally and Ishbel.

Midwifery Legislation Group

Caroline Flint reported from the group, briefly outlining its remit, which is to work towards separate legislation for the midwifery profession, apart from nursing. The Group was formed by ARM, inviting other relevant organisations to contribute to the discussion. Regular meetings held in London produced the Draft Midwives Act, but attendance at these meetings has now dwindled to 2 or 3 people. At the last meeting it was decided that these regular members would concentrate on talking at study days, conferences, etc. They will also encourage people to send information to the RCM Legislation Watch, which was initiated last year, to collect evidence that the present legislation does not work best for midwifery and maternity care. MLG also offered to help with information if people wanted to write articles in the various journals on the topic of midwifery legislation. They have also decided to hold meetings outside London, rotating around the members' towns, which may encourage a wider attendance.

MLG is short of funds, and have asked ARM for another contribution. Shelley (ARM Treasurer) reported that we have funds at present, but our future expenses need to be secured. She will liaise with Mary White, MLG Treasurer on the level of funding required.

This led to a discussion of how we decide which organisations to support. It was obvious that without a great deal more vigorous support MLG will get nowhere. There was some support for debating where we should concentrate our energies and funds, either on a campaign to strengthen UK midwifery professional status, or on an international level through our membership of ICM, or can we afford both? Our ICM membership fee this year was approx. £900, calculated on a capitation basis..

As an ARM delegate to ICM Council, Soo felt that having a foothold in there was useful, but agreed that the value of being in ICM could be debated, i.e. how effectively can we tackle the problems of international midwifery if we haven't been able to solve our own?

Midwifery Supervision

It was unanimously agreed that this is a topic requiring extensive debate, but in the short time left before the main speaker, we decided to hear two differing views, put forward by Caroline Flint and Soo Downe.

Caroline believes that supervision of midwifery is an oppressive tool. She told us that she is often contacted by midwives who have been accused of having done something wrong, and although the case may not go as far as actual disciplinary action, colleagues are aware that this particular midwife has been "called to the office" as it were. The midwife never gets a chance to "clear her name". In many cases it is an issue of clinical judgement, on which both the professionals, (supervisor and midwife), disagree. Caroline feels strongly that as a profession, we should not allow our clinical judgement to be challenged in this way, retrospectively and with no opportunity for open debate on the matter. As a profession, we spend our time making retrospective clinical judgement on other people's clinical judgement. It has to be what we do at the time, given the circumstances and with all the resources we have available at the time. Sometimes we will make mistakes. There is no question about this, but as a profession we should be able to make a clinical judgement, which maybe others would not have made, but was actually alright. A clinical decision may be questioned, but should not be criticised, and even less should be the cause for supervisory action.

Caroline believes midwifery suffers from the "nursing" model, which says there is only one "right" way of doing things, which actually doesn't work when dealing with people in a clinical situation. She agreed that good supervision is a lifeline, especially in the present climate of change in the NHS, but she firmly believes it is a millstone round our neck. Even the word "supervisor" has caused problems, it is so open to misinterpretation, by non-midwives and even those within midwifery. As an independent midwife working in many different Health Authorities, Caroline said she has over 100 supervisors who feel they can supervise her practice, and she feels this is wrong.

Soo is concerned that there is no machinery

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for appealing against an accusation made by a supervisor which does not subsequently get a hearing at a higher level. She believes that supervision is a powerful tool, but that it should be restrained by a system of appeal.

She agreed that a lot of what Caroline had said was very valid. However, she reminded us that doctors have got away with a lot of bad practice on the basis of clinical judgement. She said there should be some method of clinical audit, however it is set up. We have to get away from saying, "we're the experts, you can't challenge us". Our practice must be open to challenge.

Standards of supervision vary, and Soo said that she was coming from a different situation from Caroline's, as supervision is working very well in her Health Authority, and as far as she is aware midwives are only referred to the ENB for valid reasons. The word "practitioner" catches all those who practice, and the supervisor has a role in ensuring an accepted standard of practice for everyone.

The difficulty lies in the way complaints are handled. For instance the supervisor refers the case to the link supervisor, who refers it to Regional level. If at this stage the decision is that it should go no further, that's that – end of story. This is most unsatisfactory.

We need a system whereby if a midwife feels she has been wrongly accused, she should be able to go to a peer group, or an Expert Committee of midwives, who will then look at the evidence, look at the outcome, check the research, examine the conditions under which the midwife was employed, the situation at the time, the education etc., and decide whether in this case the accusation was appropriate or not.

A general discussion followed, with several pertinent points being brought out, including the power of a Supervisor to modify or veto, on grounds of practice standards, changes in being brought about in the present upheaval in NHS; the new requirement for adequate training as a Supervisor, where previously the post was almost an automatic adjunct to a managerial position following a scanty few days instruction; a few members cited the innovatory appointment of E & F grade midwives as Supervisors.

The general feeling was that perhaps ARM should form a working party to examine the whole concept, then issue a consensus statement, saying "this is what we want". Initially the debate must be opened up within *Midwifery Matters* and other journals, and individuals wishing to form a Working Party can then come forward at the next National Meeting.

Group practices; sub-contracting into NHS

Then followed a brief discussion of the concept of midwives taking advantage of the new consumer-led services within NHS. Trust hospitals are now buying in services for many specialities, opening up opportunities for groups of midwives to bid for providing care for a specified number of women. Important points which came out of the discussion were:

1. *Good* team/group midwifery is a sound basis for preparing to offer midwifery services to the local Trust.
2. Although some Team schemes are unwieldy, the basic concept is accepted. On-going debate is essential, to prevent complacency, (i.e. with "Teams" of 60 midwives!), and encourage eventual halving, quartering etc. until the optimum 5 or 6 midwives per team is achieve
3. Midwives need to take responsibility for their clinical decisions, and their own development, instead of relying on being sent on refresher courses, in-service study days, etc.
4. Self-employment needs to be addressed, including taxation, National Insurance contributions, personal insurance, equipment, premises, etc.
5. Contracts of services to be provided need to be carefully drawn up.

We were told that an RCM Working Party has prepared a document about sub-contracting midwifery services, which will be distributed to all RCM Branches shortly.

We then welcomed Mrs Efua Dorkenoo who had been invited to talk to us about *"The Midwifery Implication of Female Genital Mutilation"*. (See report on page 30.)

Workshops

(Held during the afternoon)

1. DEALING WITH CHILDBIRTH PROBLEMS OF FGM. Led by Efua Dorkenoo
2. DIVESTING OURSELVES OF WHITE RACISM. Led by Jo Hindley
3. CULTURE & CHILDBIRTH. Led by Sarah Montagu
4. SHARING & CARING. Led by Olga Parker

Sharing and Caring Workshop gets results!

Two participants in the last group report back that action on suggestions given by members brought satisfaction to each within days.... One had a problem of staffing levels and how to cope with the impending crisis on that midwife's patch – within three days staff complement DOUBLED!!! 'Owzat!!!?

The other, more personal, raised awareness in the group of the importance of sharing problems and making others aware of one's own distress. We spend so much time as professionals mopping others' tears that we overlook our own until the situation becomes overwhelming.

A third participant brought a success story to share.

'Divesting' ourselves of the Patterns of White Racism Workshop led by Jo Hindley

It was a bold move for me to lead this workshop. It felt very scary and I decided I would lead best and think most clearly if I let myself feel my fear and not pretend but be really genuinely 'myself'. So with my lower jaw keeping up a shivering chatter I divested my jumper to begin. There were three points I wanted to make.

First, we have been dipped or immersed in a society rife with racism right from our point zero or 'dot' when we set out on this earth and it has hurt us because it has separated us and created a distance between ourselves and other human beings who are potentially our close friends.

Second, we are all good, intelligent, loving and lovable. We have learned in our efforts to combat the spread of HIV and AIDS that it is not helpful to designate groups or individuals as 'at risk' but certain behaviours and practices are risky. Similarly it is not helpful to say people are or are not racists. However, certain patterned ways of thinking and behaving are recist and most of us at times slip into them.

Third, we have wonderful abilities to overcome the distressing distance we notice between ourselves and people of other skin colours. These abilities remain largely untapped in mainstream efforts to combat racism which have focussed on policy making. Many white people feel confused and unclear about what constitutes 'being racist' and are terrified of being accused of being racist. This fear only increases the distance between white people and people of colour. The abilities I recognise are healing abilities, our ability to cry, to shake with fear and to get angry when we have been hurt, but first of all we must be well listened to. When we are not feeling sore ourselves we are much more able to get close to others and to notice and feel sensitive about the consequences of our behaviour.

We began listening to each other. We accounted our earliest memories of when we noticed that there were people in the world with skin another colour than pink/white. Those with children talked about their embarrassment at their child's natural curiousity and uninhibited remarks: "Mummy, that lady looks like chocolate": We recognised that such remarks were not racist. We took pride in our white skin recognising that we can be proud without hurting others. We considered how it would feel to say to black people, "I'm sorry I ever thought that I was better than you" contradicting our racist feelings of superiority. We listened to each other tell of times when we wished we had said or done something about racist attacks or comments and we decided we could be bold in saying that racist behaviour is unacceptable.

Feeding back to the main group we were asked how we had defined 'white racism'. We hadn't as such. We knew what it felt like. We had recognised it in ourselves and others. It stopped us completely appreciating and loving other human beings. Most importantly we had begun to throw it off and to get on and do something about it. We felt liberated to move on it. Hooray!

Andrea Heath

The meeting closed with a plenary session, during which short reports from the Workshops were given. We thanked the Birmingham Group for hosting a really successful meeting, with plenty of good food, and ample "goodies" during the coffee breaks. Their hard work was really appreciated.

Useful references:

Harvey Jackins, *The Art of Listening*, 1981, and A Better World, 1992, pp.273-280, both published by Rational Island Publishers, Washington 98111, USA.

Evening & morning after Birmingham

Birmingham hosts of the recent national meeting decided to resurrect the former ARM tradition of whole weekend national meetings by extending our invitation to the evening and morning after the meeting before. Together with a small group of hangers-on we adjourned back to Sarah's cosy kitchen to consume the remaining chocolate fingers and sesame snaps, drink tea and evaluate the day. It was nice to not feel suddenly deserted and bereft or left up in the air., but to relax gently and say leisured goodbyes and indeed hellos to long-distance ARM travellers.

Two first-timer national meeting attenders took us up on our overnight offer (perhaps regular attenders did not read the publicity adequately to realise the offer was on?) and we set out for a bit of Birmingham night-life, to a 'balti' restaurant and then to 'Wonderbra' at the Moseley Dance Centre advertised as "an experience you'll never forget" – and we won't!

On Sunday it rained so walks were 'off' and hot relaxing baths, coffee and bagels and 'Truly, Madly, Deeply' for Alan Rickman video fans was on in ghost-romantic stead.

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The midwifery implication of female genital mutilation

(Report of Efua Dorkenoo's talk at the spring national meeting, Birmingham, 20th March 1993)

Efua told us that though she is a trained nurse, she eventually left nursing and went back to University to get a degree and ended up working with a Human Rights organisation, at a time when they were concentrating on women's health, which is closely tied to women's status in the community. Her work was an eye-opener as she looked at the issues around women's health. The group tried to raise the awareness of these issues around the world, which was, and is, very difficult, as it often means challenging cultural practices.

We were reminded that in spite of the growth of nationalism, the world is becoming a small village, with people moving all over the globe, and that as midwives we would increasingly be facing the challenge of different cultures.

Many of us were somewhat apprehensive about this topic, wondering what we were going to see and hear. Efua acknowledged these feelings and said that the most common question she is asked, is "why do these barbaric practices continue, when the problems they cause are so widely known?" To illustrate the answer, she gave a dramatic presentation of an allegorical tale called "Tradition, Tradition". It is the story of "a Kingdom in a far away continent where lived a proud people of great cultural heritage". (Efua emphasised this pride, to remind us that in our approach to nomadic women, Somali women, etc. we must remember that they are extremely proud of their heritage and tribal standing.)

These people had a deep rooted tradition that only one-legged women were considered acceptable. The women had consequently developed great skill in moving around on one leg. Tradition told them that if one leg was not cut off, it would continue to grow, rendering the woman unattractive; having two legs made childbirth difficult; a woman with two legs was not pure and clean. Another reason given was that if the woman had two legs she would run away and become a prostitute. However, one old woman said she knew how the tradition had started, saying that every year a dance competition had been held, with men and women taking part on an equal footing, in order to choose the Ruler for the following year. Musa, who had won this position for five years became worried when it seemed that one beautiful woman was a better dancer than he. Afraid of losing his position to a woman, he decreed that all women should have one leg cut off.

Successive generations of women saw no reason why the young girls should be spared the mutilation they themselves had undergone. Some young girls submitted stoically, accepting the inevitable, while others resisted and had to be held down while the deed was done. Women on crutches were unable to work in the fields, and famine threatened. A group of men and women resolved to take a stand against this tradition, for the sake for future generations. Unfortunately they were reported to the Ruler, and punished. Thus the tradition was upheld, and is now taken for granted; people have stopped asking "Why?"

This account of Efua's story loses a lot in the telling, as she had held our attention with her dramatic narrative. She had written it about 5 years ago for use with the women's groups, to demonstrate the strength of tradition in continuing these practices, which were basically designed to control women's sexuality.

Efua told us that the practice of FGM is not an "African" custom, as many people believe, and showed us a map of the continent demonstrating that in some tribal areas the practice is traditional, and in others it is not practised at all. She said it is important that we know which women are likely to have been subjected to FGM, and to what degree.

The age of the child being mutilated may vary from 6 – 14 years old. Also the degree of mutilation varies, from incision each side of the clitoris, to complete removal of labia minora, majora and clitoris. In the more drastic mutilations, the edges of the wound are sewn up tightly, leaving only a small opening at the lower end for the passage of urine and menses. FGM is carried out by women with varying degrees of skill. Intended removal of the clitoral hood can inadvertenly involve the clitoris itself. Sterile conditions are rarely present, and suturing materials vary from ordinary thread to thorns.

Proper anaesthesia as we know it is not used, with the resultant psychological trauma adding to the other problems of the victim. Well indoctrinated, some children endure the agony stoically, others need to be held down by several women, and are told that bearing the pain will help them to cope with childbirth.

There is a high rate of of morbidity, including infection of the wound itself, of the reproductive organs and the urinary tract, as well as septicaemia which is often fatal. Micturition is a long-drawn-out business, as the urine has to be forced out from behind the wound to the small

opening. Similarly menstruation causes problems, with the free flow of blood restricted, leading to the formation of clots which obstruct further flow, and eventual infection.

A problem exists in this country where families have had their young daughters mutilated while on holiday in their own countries. On return, teachers have reported dramatic character changes in previously happy, attentive children. Education authorities need to be made aware that FGM may have been carried out, and should make use of the due process of law, possibly leading to conviction for child abuse. This is one way in which to outlaw the practice.

Vaginal intercourse is difficult, and the small opening may be enlarged with a knife or forced wider as penetration is attempted. Although painful for the man also, it is often regarded as a test of manhood. However, it was interesting to learn that some men are happy for their wives not to be sewn up so tightly after childbirth, for their own comfort!

Childbirth of course was what concerned our group, and Efua had brought along the familiar female torso model which has been skillfully adapted and fitted with different parts showing the appearance of the various mutilations.

Sensitive questioning in the antenatal period is essential, as many of these women find it hard to talk about what has been done to them, but would welcome sympathetic support, and need to discuss the post-delivery repair, future sexual relations and possible rehabilitation. The midwife needs to learn where to refer the woman for these specialised services. (Dr Mary McCaffrey has specialised in rehabilitation of FGM. She works at Northwick Park Hospital, Harrow). There is an opportunity also to educate the families regarding FGM, in case the child is a girl.

Efua stressed the importance of midwives not showing revulsion or horror when first examining a mutilated woman, as this can shatter a woman's confidence and self image. Nor must she be subjected to the humiliating and degrading process of having other midwives and medical staff being called in to "come and have a look at this"!

Sometimes clitoridectomy may not be apparent, and should be considered as a possibility if there is excessive bleeding after delivery.

We all have a responsibility to get this practice stopped, and must not be persuaded that it is a "cultural" issue, it is an issue of Human Rights. The WHO is working towards abolition, though there is opposition. Nigerian midwives were supported by some obstetricians in a motion to legalise FGM.

In this country, legislation has not been fully effective so far, and there is some doubt that the Child Protection Act will be able to eradicate the practice completely. Gynaecologists have broken the law in the past, by performing FGM privately. Efua told us of a woman who was mutilated when she was 8 years old, by a British gynaecologist. She is at present sueing him because her life was dominated by the psychological and physical damage. She became a medical secretary in order to get access to her personal medical documents to support her case against him.

Forward UK (Foundation for Women's Health Research and Development) was created in 1983 by Efua Dorkenoo, to continue the activities of a working group on harmful traditional practices, set up under the auspices of the Minority Rights Group, a London-based charity. *Forward UK* has made major inroads in helping African women in the UK to become aware of their health needs and in placing such needs on the agenda of the Government and local authorities. It made a watershed breakthrough in 1991 when it was successful in having FGM brought under the UK Child Protection law as a form of child abuse." (reprinted from *Link*, the journal of *Forward UK*).

We have arranged with *Forward UK* to exchange their journal *Links* for our *Midwifery Matters*, and we have acquired the following items from them for the ARM library:

1. "Tradition, Tradition" (the story of the one-legged tribe).
2. Female Genital Mutilation – Proposals for Change.
3. Female Genital Mutilation – Counselling Guide for Professionals.
4. Child Protection and Female Genital Mutilation.

For further information: Forward UK, *Africa Centre, 38 King Street, Covent Garden, London WC2 8JT, tel. 071379 6889.*

NB

The universal childbirth picture book to be reviewed in the next issue includes a recent addition – on female genital mutilation.

LOCAL ACTIVITIES

Listed here are the reports from local contacts based on the latest questionnaires, (1.12.92 to 31.3.93). Some reported "no change", and these are listed under "Meeting times & venues". For further information on venues and programmes of local meetings, please refer to the Local Contact list inside the back page.

Sheffield
Mavis Kirkham
Meeting in members homes, days and venues vary. Recent topics discussed: Herbalism, Rebirthing. Possibility of midwives visiting Romania. Significant local changes: Change to "Team" midwifery without much continuity of care.

Kent
Diane Garland
Meetings held Monday evenings, every 6-8 weeks, in members' homes, average attendance 6-14, all welcome. Recent topics: Direct Entry, Bereavement, Parentcraft.

Portsmouth
Donna Williams
Meetings now held every 3 months due to pressure of work and previous poor attendance. Venue: St Mary's Mat.Hosp. Average attendance: 10. All welcome. Hoping to organise a Study Day next year. Significant local changes: Trust status 1st April. The last set of student midwives to qualify were not given jobs, not even temporary contracts. This got front page coverage in local press. First floor of Maternity Unit has closed and is being extensively refurbished to provide a PRIVATE wing for medical/surgical patients.

Nottingham
Amanda Moult
No set day, monthly meetings in the evening, members' homes. Recent topics: February – Mallory Stendall – Alternative Therapies. Planned for May – Siblings of S.I.D.S. victims.

Leamington Spa/Coventry
Val Hollier
Meeting monthly, Wednesday 7.30pm., average 10-20 people, all welcome. Recent topics: Fetal Alcohol Syndrome/Alcohol in Pregnancy; Government response to Winterton Report; Aromatherapy. Significant local change: Client-held records from 1.4.93.

Blackburn
Yvonne Whyte
No actual group or regular meetings yet. Invited ARM Roadshow to attend RCM Branch meeting in April – successful meeting, several new local members. Significant local changes: 5th Obst. Consultant appointed at Queens Park Hosp., Blackburn, 4th Obst. Consultant appointed at Burnley. The struggle for power goes on!

South London
Nicky Leap
Meeting 1st Wednesday each month, at Nicky's house, 8.0pm., average attendance 12-20. Topics: General discussion, support, skill-sharing.

Leeds
Olga Parker
Evening meetings held between National Meetings in members homes, all welcome. Recent topics: Setting up Team Midwifery in a local unit. Fund raising event: "Junk" stall in local market.

Manchester
Sue Cripps
Meeting 2nd Tuesday each month, in members' houses, 8.0pm. Average 8 people. Recent topics: Massage; Use of TENS; Home birth; Female condom. Hosting ARM AGM in September 1993.

Aberdeen & Grampian
Alison Scott
Meeting 1st Thursday each month in Antenatal Clinic, Aberdeen Mat.Unit, at 8.0pm. Average attendance 12, all welcome. Recent topics: Acupuncture by Kathleen Powderly, midwife; Physiotherapy, antenatal/postnatal massage and reflexology by Lesley Cochrane, physiotherapist. Significant local changes: Community midwives are to be GP attached.

Northumberland
Shona Kerr
Meeting every two months, either day or evening, at varying venues. Average attendance 5, all welcome, but not broadly advertised. Hosting ARM National Meeting in June 1993.

Southampton
Kate Walmsley
Meetings last Wednesday each month at Kate's house, 8-10pm. All welcome. Attendance 8-16. Recent topics: Midwifery Practice in Africa; Clinical aspects of Homebirth; Pre-registration students' thoughts and impressions on their training so far and midwifery in general.

Cheshire
Jane Grant
Meeting monthly as arranged, attendance 6-30. Recent meetings: Local MP re Winterton Report; Perineal care update – by local midwives (997 course research work); Listeriosis & Toxoplasmosi update – by Dr Hunter, Director c Public Health; Aspects of care of the sick newborn – update by Manager of Neonatal Unit. Significan recent change: Monthly meetings with all management levels as a result of Midwives Interest Group pressure.

Coventry
Val Hollier
Meeting 2nd Wednesday each month. Attendance 6-19. Recent topics: January – Acupuncture; February – Government response to Winterton Report (led by Jean Lewis); March – Alcohol in pregnancy & Fetal Alcohol Syndrome (led by Dr Peter Davis GP)

St Albans
Alison Heywood
Significant local changes: Rise in homebirths in East Herts. from 41 to 60 in past year, similar rise in N.W.Herts.

West Midlands
Sarah Montagu
Meeting 2nd Thursday each monti at 7.30pm (NOT on Tuesday as printed in last issue) at Sarah's house; average attendance 10; all welcome. Every other meeting is for support and sharing. Charity stall in local Rag Market raised £6 for ARM. Significant local changes: recent closure of Sorrento Maternity Unit; impending job cut at Birmingham Maternity Hospital because of huge financial losses in South Birmingham Health Authority.

Yorkshire (Leeds) Branch
In March an informal discussion o the local pilot study of 'Team Midwifery' brought fresh ideas to those involved and to others observing from the side lines. It is appreciated that most areas have up to four tries before finding the optimum system for their particular area.

Our meeting on 20th July on 'Aromatherapy in an NHS Unit',

will be at 367 Milnthorpe Lane, Sandal, Wakefield. (Off the M1 at J39, go towards Wakefield following 'Country Park' signs. Continue and turn left at 'Walnut' pub, phone 0924-255129 if lost.) **ALL WELCOME.**

• Other Groups – Meeting Times and Venues
(Full details in previous issues of Midwifery Matters, *for local contacts see back page).*

Cambridge
First Wednesday each month, 7.30 pm. Venues vary.

North London
Second Monday each month. 8pm. Holland Street Clinic, 9-11 Holland Street, London W8.

Farnborough
Second Monday each month, 8pm, in members' homes.

Gloucester
Every six weeks, usually in members' homes.

Bristol
Every month in members' homes.

West Glamorgan
Last Wednesday each month, 7pm, members' homes.

Dorset
Third Wednesday each month, 7.30pm, member's homes.

ARM AGM

Saturday 18th September 1993

9.30am-4.00pm

Venue –
The Pankhurst Centre
60-62 Nelson Street
Chorlton-on-Medlock
Manchester M13 9WP

How to get there –

By Car: From M6 come off at J21A and take M62 to Manchester. Come off at J12 and take M63 for Stretford. Leave M63 at J7 and take A56 (Chester Road) to Old Trafford. Join A57M Mancunian Way and come off at The University. Go along B5117 to Nelson Street (near M/C Royal Infirmary).

By Train: From Piccadilly walk down to bus station at Piccadilly Gardens (1/4 mile). Buses 40, 41, 42, 43, 44, 45. Ask for Royal Eye Hospital. The Pankhurst Centre is on the left of Nelson Street.

Anyone requiring crèche facilities or accommodation please notify ASAP.

Contact:
Frances Whitty – 061 225 6259
Sue Cripps – 0625 877407

Minutes of student midwives forum national meeting

17th February 1993 at Birmingham Maternity Hospital.

The meeting was chaired by Tricia who, having welcomed the fifty students in attendance (only half of whom had been given a study day to attend), introduced the day's agenda.

An overview of past meetings was given along with a summary of SMF aims. These were to elect new officers of the SMF and to exchange views before the afternoon's workshops.

Jo felt that SMF existed to offer support and the opportunity to meet and exchange ideas both in a way which is accessible and low cost.

Volunteers were asked to take forward the SMF through new officers of Secretary, Treasurer, Hosts and Regional Contacts.

During a dynamic discussion throughout the morning on issues which really concern students, volunteers emerged.

The 17 issues which were brainstormed onto a flip chart (thereby realising one of Tricia's ambitions) were all concerned with basic issues of need, not midwifery issues. It was agreed that we would use our voices in unison as students and as an empowered group to speak out against injustice.

Because it would take 100 years for 50 people to agree on one letter, the group agreed to trust individual volunteer letter writers to represent the views of the group. We agreed to target women's magazines and women's pages in the national press with the aim of empowering women to express their dissatisfaction with maternity care. We would also send open letters to all midwifery and nursing magazines.

After the reading out of specific job descriptions, Fiona Corner volunteered to serve as Secretary, Nicola Hagley as Treasurer. There were volunteers for Regional Contacts as well.

The next three meetings were agreed (*further details are advertised on the events page*):

1. **Cambridge, 20/5/93.**
2. **London University or Queen Charlotte's, 13/10/93.**
3. **Liverpool/Manchester, TBA.**

These meetings are to be held from 10am to 4pm and follow the format of a forum in the morning and afternoon workshops.

It was also agreed that one of the women's page journalists (probably the Guardian) will be invited to the London meeting.

The morning concluded with a summary of the main issues which were to be taken into the afternoon workshops together with those already scheduled.

Lunch in a very friendly, aesthetically attractive and low-priced canteen offered an opportunity to meet students from other hospitals and question yet again your choice of training college!

The afternoon workshops were preceded by summary and agreement of the options from the morning session as well as confirmation and details of the newly elected officers.

Summary of workshops from feedback at 15.30 hours

Active birth

Veronica summarised the active birth group as one which actively empowers women in what choices they want to make. Attenders discussed why some maternity carers are afraid of this.

Self directed learning

Peter felt that the abscess burst and the group spent 90% of the time saying how awful SDL is before recognising that whilst individual learners feel powerless, with the right sort of teaching, everyone gets what they want. An echo of the morning's expressed belief that learning and evaluation is a two way process.

International Homebirth Conference – Australia 1992

Debbie gave feedback quoting Elizabeth Davies' three prerequisites for midwifery:

1. Self scrutiny.
2. Validation of who we are, our expertise, etc..
3. Development of self confidence.

Baby milk action group

Discussed what we could do especially since we provide formula milk to mothers free at source in hospitals. Observed that the culturally unacceptable role of the midwife to Asian women resulted in few Asian midwives and this did not help improve the very low incidence of breastfeeders in this cultural group.

Practice after qualifying

Tina told of the difficulty in being newly qualified in midwifery as well as demonstrating much personal courage in challenging poor practice and acting according to both her own values and the code of conduct.

Electives

Tricia and Sally told an open mouthed group how they spent part of their elective in Africa as well as pointing out the opportunities to at least go to other units and into the community with independent midwives.

Finally, Jo, with the warm and hospitable style with which she had welcomed all attenders, invited people to stay on if they wanted to, then thanked everyone for attending and announced the date, time and place of the next meeting.

Birmingham were thanked for organising an excellent meeting. The day had proved to be accessible, stimulating, at times inspiring, but always inclusive and friendly. The midwives of the future represented at Birmingham may well offer women what they want if they survive the obstacles of their own training.

Carol Komaromy,
21 February 1993

SMF Contact:
Fiona Corner
74 Howard Road
Leicester
LE2 1XH
0533 705765

• ITEMS FOR SALE

Item	Price
MIDWIFERY MATTERS (back copies, each)	£2.00
BADGE (blue enamel on gilt, Pinard logo)	£3.50
PINARD Stethoscope (turned and varnished beech wood)	£6.00
PEN, Shaeffer "No Nonsense", (ARM Pinard logo)	£3.00
MUG, handmade beige stoneware, ARM logo in black. (£1 p+p)	£4.00
T SHIRT ("*MIDWIFERY MATTERS*" + Pinard logo) medium or extra large. Choice of two colours – RED (white logo), WHITE (blue logo)	£5.50
CAR STICKERS ("*MIDWIFERY MATTERS*" + Pinard, red on white)	.50
WALL POSTER "Did You Know?" (facts re midwife's role, etc.)	.50
CHOICES IN CHILDBIRTH, information leaflet	.50
RE-USE ENVELOPE GUMMED LABELS (ARM Logo) 50 labels	£1.00
"WHAT IS A MIDWIFE!" (information leaflets for clients and colleagues) (Leaflets themselves are free, you pay p+p only – £1.50 for 100, £4.50 for 500)	

Obtainable from ARM, at the address below. Please add 50p per item unless otherwise indicated. For overseas postage, please write for details.
62 Greetby Hill, Ormskirk L39 2DT.

• ARM DOCUMENTS AND REPORTS – REPRINTS

ARM has produced the following reports, memoranda and other submissions to various bodies undertaking enquiries and research into midwifery-related topics. Most of these have been subsequently published in *MIDWIFERY MATTERS* for the information and/or consultation of ARM members. Prices quoted include p+p.

Document	Price
THE VISION Proposals for Future Maternity Services (reprinted 1993)	£2.50
PROFESSIONAL CONDUCT MACHINERY, Some Necessary Changes	£3.00
"WORKING FOR MOTHERS & BABIES", (response to 1989 NHS White paper)	.50
NEW MIDWIVES BILL (Drafted by Midwives Legislation Group)	£3.00
IDEAL MATERNITY SERVICES (Submission to Winterton Committee)	.50
THE MIDWIVES SERVICES (Service Provider Specification)	.50

• N.B. BY POPULAR DEMAND!!!!

In response to many requests, we now have **ARM** Tshirts in RED, with white logo. They are the same high quality, 100% cotton, as the white ones, of which there are still some available. No price rises, (yet!).

How Womankind works for women

Womankind is an agency dedicated to encouraging positive change in the lives of women in developing countries. Everywhere in the world, women are struggling to take their full and rightful place, but in less fortunate societies, they can also be struggling against poverty, hunger and even more deeply entrenched prejudice. In such countries, it's nearly always the case that women own virtually nothing, work the longest hours and get the least food, education and health care.

Womankind works to support women in every way – body, mind and soul. So not only do we fight to overcome poverty, and to promote better health, but also for a greater awareness of women's value and potential to the societies in which they live. An awareness that also needs raising among women themselves.

Womankind works by raising funds to support women's initiatives of all kinds aimed at improving their lives. We make appeals for health and education projects. We finance programmes for women's long term development needs. And we support groups dealing with delicate issues such as sexual abuse, marital violence and women's rights.

Womankind believes that when women are unable to use, or are prevented from using, their skills to the fullest, there's a tragic waste of human resources which is detrimental to everyone. The women with whom we work in the developing world may possess very little in material terms. Usually however they are rich in terms of courage, determination, vision and optimism. All they need is the economic and educational support to convert these qualities into a higher standard of daily life. We exist to help them achieve that goal.

Womankind's Aims

To fund women's groups in developing countries and work with them to overcome the problems created by their poverty, poor education, ill health and lack of control over their own lives.

To promote awareness in the UK of women's contribution to economic and social development by allowing their voices and concerns to be heard through development education and advocacy.

I WANT TO HELP WOMEN IN DEVELOPING COUNTRIES

I wish to donate £ . I enclose a cheque*/postal order* payable to **Womankind** (Worldwide)* (* delete as appropriate)

Name: ______________________

Address: ______________________

______________________ Postcode: __________

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Womankind (Worldwide)
122 Whitechapel High Street, London E1 7PT. Tel: 071 247 6931/9431 Fax 071 247 3436

LETTERS

The personal is political

I really enjoyed the day at Cambridge and found the morning particularly stimulating, not least because it helped me to decide on which side of the 'men in midwifery' debate I really stand.

A debate which appeared divided between the personal and political was causing a lot of anguish.

I decided I agreed with the founder members of the women's movement that the presonal is political. How do women choose! Choices are not made outside of the vulnerability of motherhood, neither are they made outside of a society in which men are constructed into superior roles, above childbearing women, through patriarchy and the medical model of childbirth.

When we live in an equal society, where decisions are no longer made on the basis of gender, then women will be more adequately liberated to open the doors to men in midwifery.

I realise that we already have done this, and accept the speaker's point that it is too late to decide after men have been admitted to the profession. However the philosophical and moral issues must continue. Decisions made on the basis of 'it happens anyway' legitimates anything regardless of its desirability.

Yes, there are midwives who are neither women's advocates nor good practitioners but that is a separate argument relating to quality of care and the subsequent need for increased sensitivity and awareness. This for me is part of the function of ARM.

Perhaps when women are offered real choice we will see changes in practice which many women inside and outside the profession support.

Carol Komaromy

D Grades for newly qualified direct entrants

I don't know whether the hospital you mentioned in the last *Midwifery Matters* was West Dorset – if not, add it to your list!

I qualified six months ago in a set of ten pre-registration midwives at the Dorset School of Midwifery (now swallowed up by Bournemouth University). Nine of us who had done part or all of our clinical training at Poole were offered a fifteen hour a week 'E' grade contract there, being supposedly all that was available in the current economic climate. The remaining newly qualified midwife who had done her clinical training at West Dorset (Dorchester) Hospital, was offered a 30 hour 'D' grade, on the grounds that she did not have the necessary management experience. This, she was told verbally, would be upgraded to an 'E' grade after six months. Needless to say, during the last six months, she has received no management training and has been doing exactly the same job as all the other 'E' grade midwives, including teaching students. And, equally needless to say, she had received identical training as those of us working 20 miles down the road.

There is prejudice against pre-registration training from certain quarters. At Poole, having been told that there was no money for any jobs, the management then went on almost immediately to appoint four new 'E' grade midwives, saying they wanted experienced midwives. (Just what is an 'E' grade anyway?) Fair enough.... but the (nurse) midwives they subsequently appointed from outside only had six months experience. Then last month, another job was advertised and none of the pre-registration midwives were even short-listed (now themselves with six months' experience). Instead the job went to a brand newly qualified (nurse) midwife with no experience. All very curious!

We are in the process of investigating all this with the help of our RCM Steward, so I will let you know the results. One of the reasons we were successful at Poole in getting E grade status was that we got our very good Steward onto the issue well over a year before we were due to qualify, who agreed the principle with the management, and would recommend others to do the same.

But the whole thing stinks. It's irrational, divisive and finance-led. If management are going to take into account previous experience when it comes to grading (and I'm not at all sure they should), then why not experience gained in fields other than nursing, which are relevant? I know many pre-registration student midwives who have extensive experience in a wide variety of fields, from counselling to management.

At the last Student Midwives' Forum meeting in Birmingham, this issue of grading was an issue of great concern for many students and will no doubt be debated again at the next meeting in Cambridge in May.

Myself, I see this issue, although being a backlash against pre-registration training, to a much greater degree as being part of the insidious virus that has come with Trust status. Bursaried students are being expected to work all the unsocial hours with no extra payments, setting a very unnerving precedent. Midwives are being down-graded, hours shortened, staffing levels cut to a bare minimum. And it's all being done in isolation, nobody really knowing what all the different Trusts are doing, so it's nigh on impossible to fight.

The tragedy of it all is that issues like this drain all the midwives' attention and energy and take it away from the real issues of the women we care for and the quality of care they receive.

Tricia Anderson

Freedom of speech in the NHS

Please find enclosed the results of a survey of over 50 media health correspondents carried out recently by MSF. As you will see, it reveals that many staff working in the NHS are now less likely to talk to journalists than was the case before the health service reforms were introduced two years ago. Regional health correspondents, who have a great deal of day-to-day contact with health stories, expressed the most concern. Many said that staff will only talk to them if they are guaranteed anonymity.

The survey shows that:

- 71% of the journalists said that

fear of losing their job and/or fear of repercussions was the reason why staff would not speak out.

- 85% said that nurses were less likely to speak out than two years ago.
- 60% said that staff in Trust hospitals were less likely to speak out than staff in directly-managed hospitals.
- 71% said that gagging clauses or policies aimed at preventing staff from talking to the press are now more common than two years ago.

Trade unionists and GPs have been less affected than other groups. GPs, of course, have independent status and trade union representatives are more likely to speak out on behalf of their members as they still have some legal protection.

We feel that the worrying results of this survey show that there is an urgent need for effective action by the Department of Health so that staff feel able to express any concerns without fear of penalty. We therefore look forward to the forthcoming publication of revised Guidelines on Freedom of Speech in the NHS. We hope that these Guidelines will respond both to MSF's suggestion that a Charter of Values for all NHS staff, which sets out their rights and duties, and our view that there must be an independent element in any local procedures for handling staff concerns.

I would welcome your response to the findings of the Survey.

Bill Walsh,
National Officer, MSF The Union

Editors' Note:
MSF is a trade union representing Health Visitors Association, Medical Practitioner's Union, Guild of Hospital Pharmacists, Community Psychiatric Nurses Association, etc.. Copies of the Survey and MSF's response to Government's Draft Guidelines on Freedom of Speech in the NHS are available from Ishbel Kargar, ARM Secretary, 0695 572776.

Election to UKCC

Thank you very much for your lovely letter written on behalf of ARM which I received this morning.

My feelings are somewhat mixed. I feel quite overwhelmed, that on three occasions midwives in England have voted for my election to their statutory body. Half of me feels that I must have got some things right, otherwise I would not have received votes. We did get Direct Entry off the ground and while we lost 'our' Education Officers the fuss we made did ensure that the validation of Midwifery Courses had considerable midwifery input. The other half of me is well aware of the happenings on the ENB that were certainly not in the best interests of our profession, and where we failed to hold the line.

As you know I have particular interests in the Education of the Midwife of the future and I want to ensure that she will emerge from her training able to practice competently and confidently and able to provide the service to women recommended in the Winterton Report. My other major concern is how supervision is exercised, it has such great potential to strengthen and enhance our practice, but the danger exists that if it is not carried out appropriately it could stifle and restrict us.

I would like midwives, whether they voted for me or not, to feel free to contact me, to tell me of their problems, their successes, and where they think I can help them in any way. I find criticism just as hard to take as anybody else, but if you feel that there is something that is wrong, tell me about that too.

Thank you, all who voted for me, I will do my best to justify your confidence in me. I look forward to working on the new UKCC to move midwifery forward.

Mary Cronk
Isle of Wight

As you may well have heard, I have been elected. So I write to say a big thank you for your help and support with my election 'campaign'. I know how busy you are and am particularly grateful that you found the time to help.

I will certainly do my very best to keep midwifery strong for the future, and if there is anything I can do to help as a UKCC member please give me a call.

I was particularly pleased to have the support of an ARM nomination, so I hope that Mary and I will do my best to keep practical midwifery at the heart of all we do. I know we will work well together. Please send my best wishes to all at ARM.

All the best wishes to you.

Sarah Roch
Basingstoke

I am writing to thank ARM for the support you gave me in the UKCC elections. I am looking forward to working with the other midwife members and to maintaining a strong midwifery voice there. I would be glad to report on midwifery issues to the Journal and to receive feedback from other midwives.

Thanks again,

Alison Scouller

Thanks

I would like to thank the 'Birmingham Group' for such an informative and interesting meeting. I and many others enjoyed the day.

Sally Herbert

I was touched and grateful to receive the £50 donation for organising the ARM library. It has been well spent!

Love Sally

Polly and I would like to thank ARM for their gift of £100. One enjoyable evening was spent with our families at the ballet and another over dinner which was very much appreciated.

With thanks,

Sandra & Polly

Positive Evaluation

On the subject of evaluation forms, introduced at the winter 1992 meeting, I would like to call into question their validity. Hurtful and tactless comments were allowed to reach well-meaning individuals.

'Evaluate' from Pocket Oxford Dictionary means "find or state amount of value of". Until certain

members understand the positive meaning of evaluation, and believe in the basis of ARM – that is supporting each other as midwives, they have no positive further use.

Best wishes,

Heather Belford
Huntingdon

Mothering the mother

I was encouraged to read the letter from Meg Taylor in the Autumn 1992 edition of Midwifery Matters, in which she calls for more training in the emotional aspects of care for women prenatally, during birth and beyond.

Readers of MW will be interested to hear about an organisation called 'Birth and Bonding International', founded in the US in 1987, by Sharon Ledbetter, which is dedicated to "bringing expanded awareness and sensitivity to the process of birth".

This autumn, Sharon is coming to the UK to run a course for women to train as Childbirth Educators and 'Doula' Birth Companions. In addition to exploring the physiological aspects of pregnancy, birth and the postnatal period, the training places particular emphasis on the profound psychological, social and spiritual influences this period has on the development of the family bond and on human potential. It explores the experiences of the unborn and newborn baby, the mother and father as individuals, and the bonding family and is designed to enable the course participants to work supportively with pregnant women and couples in preparing for the birth, helping attend birth and giving postnatal and family bonding support.

There is a widespread Doula movement in the USA and this type of training is discussed at length in a new book by Phyllis and Marshall Klaus, called 'Mothering the Mother', which explores the emotional needs of women as mothers.

The training is suitable for midwives interested in the spiritual and emotional aspects of birth, mothers interested in giving support to other mothers and is also particularly useful for practitioners, such as massage therapists and acupuncturists, who might like to add the speciality of serving pregnant women and couples to their practice.

Anyone who would like further information about the course, which comprises two weekends in September, together with extensive home study, is welcome to contact me at the address below.

Yours sincerely,

Mary-Clare Buckle
189 Gloucester Road
Croydon CR0 2DW
Tel. 081 684 9351

A travelling midwife in Spain!

Your letter has caught up with me..... a travelling midwife in Spain. I am not registered here as a midwife, there's a long drawn-out process for this. However, there seems to be a change of awareness – women are beginning to realise that they have a choice. Spain is very democratic.

There is a Spanish organisation 'Aquario' outside Valencia, it's a water birth centre, run by two doctors and a midwife. Also a group of Spanish women in Barcelona, (I'm not sure if they are nurses or midwives), who do home births. I'm still investigating but they seem to be a co-operative organisation.

There is an Active Birth Teacher in Majorca, she's asked me to go over there. So, travelling to Catalonia to meet up with Joanne Reid, and to Barcelona, Valencia and Majorca, keeps me busy – much travelling, much research, much promotion..... I'll be freelancing all over the country soon!

If anyone knows of a charitable organisation able to help improve maternity services, I'd be grateful for help with finances for projector, video equipment for educational purposes, also a crash course in Spanish. I'm having Spanish lessons at the moment, it's costing a bomb!

Best wishes to you all,

Christine Peer
Carrer Del Mig 17, 03792 Parcent, Alicante, Spain.

NOTICES

Peterborough group needed!

Mary Riosto would like to get a local group going. Anyone living in the area is invited to contact her at: *13 Monument Street, Peterborough, PE1 4AQ. Telephone 0733 341207.*

Feminist archive

FEMINIST ARCHIVE has moved to Bristol. The archives hold copies of journals, newsletters etc. as well as other material on women's issues, and sell books. They are always looking for new volunteers, and say "if you have a particular area of interest or skill, such as computing or languages, we could really use your help, but you don't have to be skilled, just keen and interested". Their regular newsletter costs £5 per year. They are now at: *Trinity Road Library, St Philips, Bristol, BS2 0NW. (0272 350025).*

Warren Weaver Fellowship – 1 Year in New York

The ICM have circulated a notice inviting nominations to the above fellowship, which offers 1 year residency at the Rockerfeller Foundation offices in New York. Unfortunately we received the circular too late for this year's nomination, but as it is an annual fellowship, we give the background information, so that members may start considering their applications for next year. (usual closing date 1st March).

Nominees, says the Foundation, should have the highest potential; they are "likely to come from a wide variety of backgrounds, but will be in the early stages of their careers following graduate work or professional training." The programme provides the successful nominees with first-hand experience in the field of philanthropy while enabling the Foundation to acquire fresh perspectives on its work. Each of the six to eight Fellows are given an adequate stipend to live in the New York area for a year and devote that year to working with the Foundation's officers on one of their programmes. The starting date of the fellowships is usually around 15th September.

The Foundation has three

divisions – Agricultural, Health and Population Sciences, in addition to its Global Environment Initiative. Some of the studies relevant to maternity care include, 1.scientific research into reproductive biology; 2. evaluation of how existing contraceptive methods can be modified to improve their acceptance, safety and effectiveness; 3. research on the interrelations between the status of women and fertility that clarifies how sociocultural conditions interact with technology, health care and delivery of family planning services. The Foundation supports efforts to enhance integrated health care and family planning capabilities, and has chosen to focus on maternal and child health.

A leaflet giving full details of the work of the Foundation is available from ICM. Address:
Joan Walker, Secretary General, *ICM., 10 Barley Mow Passage, Chiswick, London, W4 4PH. Tel. 081 994 6477*

"Alyson – A Story of a Green Witch"

A touring play about a midwife in the Middle Ages who is condemned for witchcraft. A very human story, relevant today because it represents the struggle women still have as healers and medics. The play will be touring regionally in the autumn of 1993. Further information, bookings, dates, etc. contact:
Rosa Productions, *The Basement, 1 Compton Terrace, London, N7 2UN. (071 354 8447)*

Further tales of the expected

A book of poetry on a midwifery theme, written by Maureen Beck, community midwife in Somerset and member of ARM. She is hoping to raise funds for her ICM trip by selling the booklets, £2 each. Contact her at:
4 Sealey's Cottages, Creech St Michael, Nr Taunton, TA3 5DP. (0823 442108)

Caduceus Journal – spring issue devoted to "Birth"

A special issue presenting a major and controversial survey of current practices in obstetrically managed births and the alternatives available to women, in the active birth movement and complementary medicine. Keynote articles:

1. Shopping around for pregnancy care and type of birth;
2. Active Birth – reaffirming that birth is a transformative experience, loss of feminine power of birth and mothering leads to alienation and disease of society;
3. Survey of clinical trial results to date finds against continued use of many obstetric procedures;
4. Dramatic improvements in results when midwives are prime attendants;
5. Independent midwifery practice – a way of changing from obstetric models of care;
6. Bereavement support following stillbirth and neonatal death, parents as well as professionals;
7. Herbs for pregnancy and birth;
8. Chinese Medicine – maximising human potential in pregnancy and birth;
9. The Birth of a Father
10. Resource Guide – organisations in the field.

Caduceus, *38 Russell Terrace, Leamington Spa, CV31 1HE (0926 451897)*

Women's National Commission

Caroline Flint has been appointed RCM Representative to the commission, a body of assorted Women's Organisations, which together advise the Government on matters to do with women. Contact her if you have any issues which you think this body should be addressing.
071 498 2322

Scottish Birth Teachers Association

Starting October 1993 a 2 year course designed for women and midwives wishing to facilitate birth groups for pregnant women or couples. Emphasis on developing appropriate group skills, understanding bodywork, teaching movement, exercise and relaxation, acquiring broad knowledge base of childbirth and related issues. Study days will be held in Edinburgh on Saturdays from 9.30 to 4.30, at approximately 5 week intervals, with longer breaks during summer and mid-winter, 8 days per year in total. The course is limited to 15 places, and costs £250 per year, payable in advance. Contact:
Nadine Edwards, *40 Leamington Terrace, Edinburgh, EH10 4JL*

Lothian home birth support group

Founded January 1993 in response to growing need for information and support for women in the area seeking a home birth. A wide range of experience within the group, including a comprehensive and useful contact list for enquirers. Regular meetings in members' homes, projects in hand include designing a poster for display in libraries, health centres, etc., also compiling an information pack for pregnant women. Contact:
Chris – *031 334 0326*
or Caroline – 0506 34128

News from Germany

The following was contained in a letter to me from one of our members, an independent midwife, in Germany:

"The Health Committee Report has been fully translated and has appeared in the monthly journal of the "big" midwifery association, (mostly hospital midwives). The "big" Association has cautiously now started speaking out in favour of homebirths – there's for a change!

Next week-end will be the annual meeting of the liberal midwives – a small group of dedicated, but overworked women, same as usual."
Contact:
Ishbel Kargar

Caring for friends

Further correspondence has been received, which indicates that the problems of midwives caring for friends and relatives during pregnancy and labour is far from resolved.

ARM send support and best wishes

Important

To ARM members and regional

contacts. Please do not use the general information leaflet (Printed in blue) prior to Spring 1992.

Gaps now filled – many thanks!

There was a good response to my request for people to fill the gaps in our lists, as follows:

Midwives Journal Editor

Several members expressed interest in this work, and were referred to Clare Flook for further information. Each person was asked to write to Joanna Trevelyan, (Deputy Editor of Nursing Times), with CV and statement of intent, to which Joanna replied. The applicants still interested were interviewed at NT offices on 1st April, with the result that Jenny Hall was appointed Editor of Midwifery Journal to take effect immediately. We congratulate Jenny, and hope she will enjoy her Editorship as much as previous Editors have done.

Arm Delegate to ICM Council

Olga Parker will take Caroline Flint's place at the Council meeting in Vancouver, which takes place during the week before the Congress. At the AGM in September 93 elections will be held to select two delegates for the following three year term.

Joint Meetings ARM/ RCM/ASM

Frances Black is pleased to be joined by Jane Flanders and Yvonne Whyte at these meetings. Having three representatives will ensure continuity in future, and spread the load for them all.

ARM Steering Group

The constitution permits the Steering Group to fill casual vacancies until the next AGM. There were two offers to join the Group, which were agreed at the Steering Group Meeting on Friday 19th March. These were Jane Duggan and Jane Manley, who were welcomed to the Group. Gillian Hawksworth also responded to the advert but her letter was not received until after the Spring National Meeting. She has therefore been invited to attend the Group's next meeting in June. This fills the three vacancies advertised, but in the meantime Amanda Moult has resigned from the Steering Group for personal reasons, which leaves us with one vacancy, which no doubt will be filled at the AGM.

My grateful thanks to all who responded so quickly to this request for volunteers. It's good to know *Midwifery Matters* is read so carefully!

Ishbel.

STOP PRESS

A critical look at supervision

There is a proposal to set up an ARM Working Party to look at the whole issue of midwifery supervision, and eventually produce recommendations for future practice. If the Summer National Meeting (19 June) agrees with the proposal, the Working Party will need instances of 'good' supervision, and the 'not so good', as well as the downright bad.

Is your supervisor a respected colleague? Is she also a manager? Can you approach her for help with a problem and be sure she'll remember to take off her 'management hat'? If so, write in and say so. If not, please say how you think the situation could be improved.

As a supervisor, do you feel able to act as 'counsellor and friend' to your midwifery colleagues? If you are also a manager, do you feel supported by your superiors when you have to act as a supervisor rather than a manager? Do you believe that they are fully aware of the different responsibilities of these two roles? What would improve your situation?

The examples will be used confidentially by the Working Party, to inform the debate, but if you'd rather omit identifying details, i.e. Health Authority, Hospital, etc., please do so. It will be assumed that all examples are actual instances and experiences.

Please write, before 15th June if possible, to:
'Supervision', c/o Ishbel Kargar, (Secretary), 62 Greetby Hill, Ormskirk, L39 2DT.

GLEANINGS

Maternal weight and fetal wellbeing

Two pieces of medical research have highlighted the danger of an obsessive focus on women's weight in pregnancy.

1. A study of over 1,000 pregnant women showed that the centile chart of maternal weight gain was not effective in detecting women who gave birth to small for gestational age (SGA) infants. Low maternal booking weight was the most effective maternal weight measurement for detecting SGA infants. (It is interesting to note that it was this measure, and not body mass index, weight/height^2, which provided the best prediction.) Almost half of all women lost or failed to gain weight over a two-week period in the third trimester. Maternal weight needs to be recorded only at booking, with the exception of those women in whom nutrition is of concern. The authors conclude that the routine weight of pregnant women, after the initial weighing at booking, may produce unnecessary anxiety and should cease. (M.G.Dawes & J.G.Grudzinskas, British Journal of Obstetrics & Gynaecology, 98, Feb.1991, 189-194)

2. It is almost routine for overweight pregnant women to be urged by midwives or doctors to cut back on food. A warning of the danger of weight gain restriction in obese women during pregnancy is given in a study by Sally Lederman. She points to the many ill consequences for the infant if obese mothers' diets are restricted. Both birthweight and subsequent grown have been found to be lower in infants of obese women who dieted during pregnancy, compared with a matched control group. Gestational difficulties faced by such women may be due to problems such as hypertension and diabetes. With food restriction, further metabolic changes may occur in the mother, giving rise to more nutritional problems for the fetus. (Sally Lederman, in Reproductive Perinatal Epidemiology, Eds.J.S.Kraus & M.Bulterys, 1991, CRS Press, 99-111)

EMPOWERMENT, Occasional Journal of the Early Childhood Development Unit, based at

University of Bristol, Vol.2 no.2, 1993, pp 4-5.

(NB. Apparently routine antenatal weighing has stopped at Fairfield General Hospital, near Bury. So at least somebody is reading the research – any other offers?)

Baby Milk Action update

1. The WHO/UNICEF International Code bans **All** forms of promotion of bottle feeding. Companies have recently concentrated on giving free milk to hospitals as it is such an effective way of hooking a mother and baby on their products. Now the boycott is gradually forcing an end to this practice. Nestlé is stepping up its other promotional activities and introducing new techniques to get babies on the bottle. Hospital visits by company reps have increased (wasting health workers' valuable time), large quantities of free milk are given prior to agreements, cash payments are made if a company's milk is used, gifts are made to hospitals, free supplies of "specialised" infant formula are given..... Other practices include inducements to doctors, promotion of follow-on milks, direct advertising and misleading information. All such marketing harms breastfeeding and is therefore banned by the International Code. Even ignoring the free supplies issue, Nestlé still threatens breastfeeding more than any other company. Nestlé controls over half of the world baby milk market which is valued at US$8 billion. This would grow to around US$38 billion if every baby in the world were bottle fed for 6 months. Nestlé is clearly unwilling to forgo such potential profits without being forced to.

2. UK sales of Nescaf fell by 3% in the year after the Church of England General Synod joined the boycott campaign. At the same time, Nestlé increased the amount it spends on advertising Nescaf by 27% to £19 million. For Nestlé, which holds just over half the UK instant coffee market, this drop in sales represents nearly ½ million kg (5 million 100g jars), or between £5.5 & £8 million. Sales of all other brands of instant coffee fell by less than 1% over the same period. Nescaf sales suffered despite spending an enormous £4 million more on advertising. Its main competitor in the instant coffee market decreased its advertising spend by over 40% but saw a slight increase in sales. Nestlé has fallen from 3rd to 4th place in the table of leading grocery brands. The cost of the campaign to Nestlé must also include the money spent on public relations exercises and the expense of so many staff, including top executives, responding to the boycott.

UPDATE Issue no.10 March 1993, BABY MILK ACTION, 23 St. Andrews Street, Cambridge, CB2 3AX. 0223 464420

Ultrasound re-assessment called for

AIMS has decided to bring out a special issue of the Journal on ultrasound. We have been writing to Ministers of Health for the last twelve years about antenatal scanning and our growing concern. The time has come for re-assessment of risks and benefits, and for us to share our anxieties with our readers more fully, because:

1. Scans which were originally intended for women with potential problems are now given to almost every pregnant woman and are part of routine care.

2. There is no adequate evidence that this is beneficial, and huge resources are involved.

3. The number of scans per baby has increased – some members report nine or more.

4. The machines have become more powerful and there is inadequate information or control on levels of output.

5. Many scans are being carried out by staff who are poorly trained and do not understand potential risks and how to minimise them.

6. Scans are being used on more women in very early pregnancy when major organs are being formed.

7. With the development of the vaginal probe the ultrasound now gets nearer to the baby with less intervening protective tissue.

8. There is more use of Doppler ultrasound (which may carry greater risk) to study blood flow in the uterus and the baby.

9. Some clinicians and researchers are exposing women and babies to long periods of ultrasound – an hour or more.

AIMS QUARTERLY JOURNAL Vol.5, no.1, Spring 1993

What is Support?

Support is unconditional. It is listening, not judging, not telling your own story.

Support is not offering advice. It is offering a Kleenex, a touch, a hug... caring.

We are here to listen... not to work miracles.

We are here to help women discover what they are feeling... not to make the feelings go away.

We are here to help a woman identify her options... not to tell her which options to choose.

We are here to discuss steps with a woman... not to take steps for her.

We are here to help a woman discover her own strengths... not to rescue her and leave her still vulnerable.

We are here to help a woman discover she can help herself... not to take responsibility for her.

We are here to help a woman learn to choose... not to make it unnecessary for her to make difficult choices.

Anonymous in SPECIAL DELIVERY, vol.16 no.1 Winter 1992-93

BOOK REVIEWS

Women Healers Through History

Elisabeth Brooke

The Women's Press, 1993.
210pp. ISBN: 0 7043 4324 X. £7.99

This is an outline of the lives and works of some of the women who have worked as healers, physicians and midwives from ancient Egypt to modern London. Covering some 3-4,000 years in about 200 pages is bound to cause some problems, and this book is spoiled by a whistle-stop approach to its subject. There is much to interest midwives by way of an introduction to the history of female work in health care, but the book is generally too superficial and simplistic in its analysis. It tends to veer from short descriptive accounts of the lives of women healers to rather idealistic polemic, losing the sense of real women acting in real societies between the two.

A further problem is posed by the number of inaccuracies I spotted in the text in passages dealing with something I already knew about. This made me wonder whether there were similar inaccuracies in the sections of the book which dealt with subject matter which was new to me. There are sections on 'Jilly Rosser and the radical midwives' (by which Elisabeth Brooke seems to mean independent midwives) and Wendy Savage which contain enough inaccuracies to render them slightly confusing to anyone not already familiar with the arguments involved in these cases.

I'm not sure why The Women's Press describe it (on the back cover) as "the definitive history of women's invaluable contribution to healing". Such hyperbole is misplaced. Nonetheless I did enjoy the book on the whole and found it very readable once I accepted its limitations. Also worth mentioning is the wonderful cover design and the very sad dedication and acknowledgements. 'Women Healers' would be a fairly useful and probably much read addition to any midwifery or personal library.

Deborah Hughes,
Midwife.

EVENTS

11th-13th June 1993
13th-15th August 1993

Birthworks
HOLISTIC BIRTH TRAINING
Exploring with like minded people the elements missing in midwifery training today seeking ENB approval
Venue – A beautiful Midlands village
Cost – ***£115 full board and educational course booklets***
Contact – Carmella B'Hahn – Birthworks
4E Brent Mill Estate, South Brent, Devon, TQ10 9YT
Tel. 0364 72802

19th June 1993

ARM
SUMMER NATIONAL MEETING
Jean Keats talking on team midwifery – a day looking at choices in midwifery – post Winterton walk on Sunday – hills, Roman wall, fresh air. Please contact if creche or accommodation is needed.
Venue – Hexham, Northumberland
Cost – *£10 and £8*
Contact – Shona Kerr
Tel. 0434 604439

26th June 1993

Midwifery Today
STUDY DAY
Anne Frye – teacher, author, midwife
Katy Polone – midwife and herbalist
Christiana Edem – midwife and professor
Hands on herb workshop, suturing, shoulder dystocia, mechanism of labour and haemorrhage.
Venue – Downtown Hilton Hotel, Seattle, WA
Contact – 1-800-743-0974, (503) 344-7438

31st July-1st August 1993

Midwifery Today
URBAN RETREAT
Anne Frye – author and midwife
Katy Polone – midwife and herbalist
Jan Tritten – publisher of Midwifery Today and midwife
Venue – Hofstra University, Long Island, NY
Contact – 1-800-743-0974, (503) 344-7438

13th October 1993

Student Midwives Forum
ACTIVE MANAGEMENT OF THE FIRST STAGE OF LABOUR AND EPIDURALS
London University or Queen Charlotte's
Further details to be confirmed

23rd October 1993

East Suffolk Homebirth Support Group
CHILDBIRTH: NEEDS, DREAM AND REALITY?
Michel Odent, Beverly Beech, Yehudi Gardan, Joan Cameron of 'The London'.
Venue – Suffolk Grange Hotel, Ipswich
Cost – ***£50 (£25 students, medical trainees, midwives and unwaged)***
Contact – 0728 723012 (evenings)

4th-6th March 1994

Midwifery Today
THIRD ANNUAL CONFERENCE
Venue – Eugene, OR
Contact – 1-800-743-0974, (503) 344-7438

SUBSCRIPTIONS

PERSONAL SUBSCRIPTION FORM

(Other organisations, groups, midwifery schools/colleges, etc. please write for details)

Subscriptions may begin at any time of the year, to cover 4 issues of MIDWIFERY MATTERS, beginning with the most recent. Members are entitled to reduced entrance fee at all ARM meetings, refund of expenses over £10 for travel to National Meetings, (not AGM), and free use of ARM Lending Library.

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Please join any group which interests you!

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MIDWIVES JOURNAL (ARM's quarterly supplement in Nursing Times)
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IS THERE A REGIONAL CONTACT NEAR YOU?

Some local groups cover a large area, and other areas have no local group at all. If your area is not covered by this list, or if there is no local group near you, why not get together with one or two colleagues to start your own? Contacts are also needed in all areas, to provide information on the local maternity care situation. Please write to Ishbel Kargar, 62 Greetby Hill, Ormskirk, L39 2DT.